

1
 3564
 MARYLAND STATE DEPARTMENT OF HEALTH
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
 CERTIFICATE OF DEATH
 08553

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Wicomico			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) (Rural) Parsonsburg				c. LENGTH OF STAY IN lb Life Time			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION R.D.# 1				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First EDGAR Middle QUINTON Last ADKINS				4. DATE OF DEATH Month JULY Day 31st Year 1961			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 16, 1881	9. AGE (In years lost birthday) 80 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Farmer		10b. KIND OF BUSINESS OR INDUSTRY Farming		11. BIRTHPLACE (State or foreign country) Rural-Parsonsburg, Md.		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME Joseph James Adkins				14. MOTHER'S MAIDEN NAME Catherine Holloway			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT Mrs. Elizabeth E. Adkins (Wife) R.D.# 1 Parsonsburg, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral hemorrhages DUE TO 331X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) Benign prostatic hypertrophy DUE TO Benign prostatic hypertrophy PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Benign prostatic hypertrophy						INTERVAL BETWEEN ONSET AND DEATH 49. 3 yrs.	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) N/A					
20c. TIME OF INJURY Month, Day, Year Hour o. m. N/A p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) N/A		20f. (City or town) (County) (State) N/A	
21. I certify that (I) (this hospital) attended the deceased from Dec 1954 to 7/31 , 19 61 , that (I) (we) last saw the deceased alive on 7/31 , 19 61 , and that death occurred at 7:31 AM, from the causes and on the date stated above.							
22a. SIGNATURE Dr. Earl M. Beardsley				22b. DATE August 2/1961			
22c. PHYSICIAN'S NAME (Type) Dr. Earl M. Beardsley				22d. ADDRESS Maryland Ave. Salisbury, Maryland			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Aug. 3, 1961		23c. NAME OF CEMETERY OR CREMATORY Forest Grove Cemetery-R.D.# Parsonsburg, Maryland		23d. LOCATION (City, town, or county) (State) Parsonsburg, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE HOLLOWAY & COMPANY SALISBURY MARYLAND				25a. REC'D BY REGISTRAR AUG 7 '61		25b. REGISTRAR'S SIGNATURE Arthur L. Kane	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8566

CERTIFICATE OF DEATH

Reg. Dist. No. 08558

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Worcester ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Whaleyville 23X-2	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Peninsula General Hospital		d. STREET ADDRESS Rural	
3. NAME OF DECEASED (Type or print) First Arch Middle Baker Last Baker		4. DATE OF DEATH Month July Day 29 Year 1961	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 30, 1887
9. AGE (In years lost birthday) 74 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farming		10b. KIND OF BUSINESS OR INDUSTRY Own farm	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Isaac Baker		14. MOTHER'S MAIDEN NAME Katherine Donoway	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 218-30-0966	
17. INFORMANT Manford Baker - Traphol		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Subarachnoid Hemorrhage 330X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 12 hrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from July 29, 1961 to July 29, 1961 , that I last saw the deceased alive on July 29, 1961 and that death occurred at 3 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Sam J. Gilmore		ADDRESS (Street, city or town, state) Salisbury, Md DATE SIGNED July 29, 1961	
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial Aug. 1, 1961		22b. DATE THEREOF	
22c. NAME OF CEMETERY OR CREMATORY MeChanic's		22d. LOCATION (City, town, or county) (State) Millsboro Del.	
23. FUNERAL DIRECTOR'S SIGNATURE Henry H. Watson		ADDRESS Pocomoke City, Md.	
24a. REC'D BY REGISTRAR AUG 3 '61		24b. REGISTRAR'S SIGNATURE Arthur L. Kline	

M

1885

CERTIFICATE OF DEATH

REGISTERED

TO THE GENERAL PUBLIC

OF THE

STATE OF

NEW YORK

IN

THE

YEAR

1885

THE

DEATH

OF

THE

STATE

OF

NEW

YORK

Printed and Published by the
State of New York, Albany, 1885

Price 25 Cts.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
8565 CERTIFICATE OF DEATH 08560											
1. PLACE OF DEATH a. COUNTY Wicomico b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury c. LENGTH OF STAY IN lb 1 day d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Deer's Head State Hospital						2. USUAL RESIDENCE (Where deceased lived, If institution; Residence before admission) a. STATE Maryland b. COUNTY Kent c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chestertown d. STREET ADDRESS Kent Street e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) Lida			First Lida Middle E. Last Bowers			4. DATE OF DEATH July 19 19 61			Month July Day 19 Year 61		
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Apr. 17, 1890		9. AGE (In years last birthday) 71 yrs.		IF UNDER 1 YEAR Months 14 Days 37	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY Housewife				11. BIRTHPLACE (County & State, or foreign country) Kent Co. Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Wm. Thos. Edwards						14. MOTHER'S MAIDEN NAME Fannie Louise Maslin					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no				16. SOCIAL SECURITY NO. 220-34-9932		17. INFORMANT Address Mrs. Lida Blake Childs, Maryland					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral thrombosis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Generalized arteriosclerosis DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										INTERVAL BETWEEN ONSET AND DEATH 1 month 5 years	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)		(State)	
21. I certify that (If (this hospital) attended the deceased from July 18 , 19 61 to July 19 , 19 61 that (I) (we) last saw the deceased alive on July 19 , 19 61 , and that death occurred at 12:20 P.M. , from the causes and on the date stated above.											
22a. SIGNATURE Lee L. Lawry				M.D. Lee L. Lawry, M.D.		ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED 7/19/61			
22c. PHYSICIAN'S NAME (Type) Lee L. Lawry, M.D.				22d. ADDRESS Deer's Head Hospital; Salisbury, Maryland							
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF July 22, 1961		23c. NAME OF CEMETERY OR CREMATORY Chester Cemetery		23d. LOCATION (City, town or county) Chestertown, Maryland		(State)			
24. FUNERAL DIRECTOR'S SIGNATURE J. Willis Wells				ADDRESS Chestertown, Md.		25a. REC'D BY REGISTRAR JUL 24 '61		25b. REGISTRAR'S SIGNATURE Arthur S. Kraus			

(M)

3363

Michigan

Salisbury

1 day

Chesapeake

Ham's head and neck

Ham's head

like

loose

July

Apr. 11, 1900

Tennis White

Housewife

Ham's head

Ham's head

Ham's head

no

3-10-1900

General

General

July 12

12:30 P.M.

Wash

[Handwritten signature]

Joe L. Henry, N.D.

Don't send anything; call later

July 22, 1901

[Handwritten signature]

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

08561

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury			c. LENGTH OF STAY IN 1b 			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Parsonsburg - Powellville (Rural)	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Pen Gen. Hospital				d. STREET ADDRESS R.D.# 1		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First LLOYD Middle BURTON Last BRITTINGHAM				4. DATE OF DEATH Month July Day 29th Year 1961			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Feb. 18, 1903	
9. AGE (In years last birthday) 58 yrs.		IF UNDER 1 YEAR Months 5 Days 11		IF UNDER 24 HRS. Hours Min. 			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY Farming		11. BIRTHPLACE (State or foreign country) R.D.# Powellville, Md.		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME Lemuel B. Brittingham				14. MOTHER'S MAIDEN NAME Emma Rounds			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) [If yes, give war or dates of service] No				16. SOCIAL SECURITY NO. 			
17. INFORMANT Mrs. Elsie M. Brittingham (Wife)				Address R.D.# 1 Parsonsburg - Powellville, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Thrombosis 332X DUE TO Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last. (b) _____ DUE TO (c) _____							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) N/A			
20c. TIME OF INJURY Month, Day, Year Hour a. m. N/A p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) N/A		20f. (City or town) (County) (State) N/A	
21. I certify that (I) (this hospital) attended the deceased from 7/26 5:55A.M. to 7/28 1961 , that (I) (we) last saw the deceased alive on 7/29 1961 , and that death occurred at M , from the causes and on the date stated above.							
22a. SIGNATURE David J. Gilmore				22b. DATE SIGNED July 29/1961			
22c. PHYSICIAN'S NAME (Type) Dr. David J. Gilmore				22d. ADDRESS Medical Center Salisbury, Maryland			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF July 31, 1961		23c. NAME OF CEMETERY OR CREMATORY Parsons Cemetery		23d. LOCATION (City, town, or county) (State) Salisbury, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE HOLLOWAY & COMPANY				ADDRESS SALISBURY MARYLAND		25a. REC'D BY REGISTRAR DATE JUL 31 '61	
				25b. REGISTRAR'S SIGNATURE Arthur L. Travis			



TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

8/21/61 File # G293
MMB 2568

08562

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Delaware</u> b. COUNTY <u>Sussex</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>				c. LENGTH OF STAY IN 1b <u>1 day</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Peninsula General Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Laurel - Rural</u>				f. STREET ADDRESS <u>Sharptown Road</u>			
3. NAME OF DECEASED (Type or print) First <u>Venison</u> Middle <u>Leroy</u> Last <u>Brown</u>				4. DATE OF DEATH Month <u>July</u> Day <u>8</u> Year <u>1961</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>Negro</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>April 27, 1937</u>	
9. AGE (In years last birthday) <u>24</u> yrs.		10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>		11. IF UNDER 24 HRS. Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Day Laborer</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Matthews Poultry Co.</u>			
11. BIRTHPLACE (State or foreign country) <u>Delmar, Del., RFD</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>Donald L. Brown</u>				14. MOTHER'S MAIDEN NAME <u>Mae L. Roberts</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u>				16. SOCIAL SECURITY NO. <u>3/22/56 - 1/14/58 222-22-7496</u>			
17. INFORMANT <u>Mrs. Preston A. Brown, Laurel, Del. RFD</u>				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Lobar Pneumonia Rt. and L. Lungs</u> DUE TO Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause lost. (c) <u>Congestion and Edema of Lungs</u> <u>Congestion and Edema of Brain</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u> </u> <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>July 8, 1961</u> to <u>July 8, 1961</u> , that (I) (we) last saw the deceased alive on <u>July 8, 1961</u> , and that death occurred at <u>4:20 AM</u> from the causes and on the date stated above.							
22a. SIGNATURE <u>A. C. Mitchell</u>				22b. DATE SIGNED <u>7/14/61</u>			
22c. PHYSICIAN'S NAME (Type) <u>A. C. Mitchell, M.D.</u>				22d. ADDRESS <u>211 Maryland Ave., Salisbury, Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				23b. DATE THEREOF <u>July 11, 1961</u>			
23c. NAME OF CEMETERY OR CREMATORY <u>Zion Church Cemetery</u>				23d. LOCATION (City, town, or county) (State) <u>Near Sharptown, Maryland</u>			
24. FUNERAL DIRECTOR'S SIGNATURE <u>J.J. Frampton and Son, Federalsburg, Maryland</u>				25a. REC'D BY REGISTRAR <u>JUL 17 '61</u>			
25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kenna</u>				25c. REGISTRAR'S SIGNATURE			

1947

OFFICE OF THE

1948

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 3—Film G291 7/24/61 iwk

8569

CERTIFICATE OF DEATH

Reg. Dist. No. 08563

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) b. COUNTY <u>Wicomico</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury (John B. Parsons Home)</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury (John B. Parsons Home)</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>TENINSULA GENERAL HOSPITAL</u>				d. STREET ADDRESS <u>405 Park Ave.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Eleanor E. CAREY</u>				4. DATE OF DEATH Month Day Year <u>JULY 17 1961</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <u>WIDOWED</u> <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Mar. 30, 1876</u>	
9. AGE (In years last birthday) <u>86</u> yrs		IF UNDER 1 YEAR Months Days Hours		IF UNDER 24 HRS. Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House Work</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>		11. BIRTHPLACE (State or foreign country) <u>Pittsburgh, Penna.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U S A</u>	
13. FATHER'S NAME <u>David R. Sutherland</u>				14. MOTHER'S MAIDEN NAME <u>Christina Umstead</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>INFORMANT</u> <u>Records: John B. Parsons Home for the Aged</u> <u>Lemon Hill, Maryland Salisbury, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause lost. (b) <u>332X</u> DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH <u>72 days</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>N/A</u>					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>N/A 19</u>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>N/A</u>		20f. (City or town) (County) (State) <u>N/A</u>	
21. I certify that I attended the deceased from <u>4/5</u> , 19 <u>61</u> , to <u>7/17</u> , 19 <u>61</u> , that I last saw the deceased alive on <u>7/17</u> , 19 <u>61</u> , and that death occurred at <u>1:10 P.M.</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>F. R. Gramse</u>		ADDRESS (Street, city or town, state) <u>Salisbury, Md.</u> DATE SIGNED <u>July 17/61</u>					
PHYSICIAN'S NAME (Type) <u>Dr. Fred R. Gramse</u>		S. Division <u>St. Salisbury, Maryland</u>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>July 19/1961</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Parsons Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Salisbury, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>HOLLOWAY & COMPANY</u>		ADDRESS <u>SALISBURY MARYLAND</u>		24a. REC'D BY REGISTRAR <u>JUL 19 '61</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>	

NEW YORK, NOV. 20, 1938

Mr. J. P. Morgan

45 Wall Street

New York

Dear Mr. Morgan:

Re:

Enclosed for you are two copies of the report of the

Committee on the Administration of the Federal Reserve System

for the year 1937-1938.

The report is being distributed to all members of the

Board of Governors and to all members of the Federal Reserve

System.

Very respectfully,

Wm. C. Sullivan

Chairman, Board of Governors

Federal Reserve System

Washington, D. C.

Enclosed for you are two copies of the report of the

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

8570

Items 8, 9 & 10 Film 6291 7/26/61 iwk

08564

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Somerset	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Westover	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION DEER'S HEAD STATE HOSPITAL		d. STREET ADDRESS 17 X-2	
3. NAME OF DECEASED (Type or print) First Mary Middle Elizabeth Last COLLINS		4. DATE OF DEATH Month July Day 17 Year 1961	
5. SEX Female	6. COLOR OR RACE Colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 24, 1876
9. AGE (In years last birthday) 85 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME James Pinkett		14. MOTHER'S MAIDEN NAME Dealah Pinkett	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. 220-16-7641	
17. INFORMANT Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia due to DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic cardiovascular disease, decompensated DUE TO (c) Arteriosclerosis, general		INTERVAL BETWEEN ONSET AND DEATH 4 days Years Years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Nephrosclerosis		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from July 10, 1961 to July 17, 1961 , that (I) (we) last saw the deceased alive on July 17, 1961 , and that death occurred at 8:25 P.M. M. from the causes and on the date stated above.			
22a. SIGNATURE V. Juerman		22b. DATE SIGNED 7/17/61	
22c. PHYSICIAN'S NAME (Type) V. JUERMAN, M. D.		22d. ADDRESS DEER'S HEAD STATE HOSPITAL Salisbury, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 7/21/61	
23c. NAME OF CEMETERY OR CREMATORY St James		23d. LOCATION (City, town, or county) (State) Westover, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE William H. James Jr. Princess Anne, Md		25a. REC'D BY REGISTRAR JUL 24 '61	
ADDRESS		25b. REGISTRAR'S SIGNATURE Charles S. Kinn	

CERTIFICATE OF DEATH

1957

(M)

Decedent

Age

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
CERTIFICATE OF DEATH									
1. PLACE OF DEATH a. COUNTY Wicomico		b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Salisbury		c. LENGTH OF STAY IN 1b MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland		b. COUNTY Dorchester	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Peninsula General Hospital				e. STREET ADDRESS 9 School House Lane		f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Sarah		First Lizzie		Middle Cornish		Last Cornish		4. DATE OF DEATH July 14 19 61	
5. SEX Female		6. COLOR OR RACE Colored		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Sept. 15, 1878		9. AGE (In years last birthday) 82 8 1/2	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Laborer		11. BIRTHPLACE (County & State, or foreign country) Dorchester County, Md.		12. CITIZEN OF WHAT COUNTRY? USA		IF UNDER 1 YEAR Months Days Hours Min.	
13. FATHER'S NAME James Cornish				14. MOTHER'S MAIDEN NAME Silista Lane					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. -----		17. INFORMANT Elizabeth Streeter, Cambridge, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerosis, general - advanced DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) 21. I certify that (I) (this hospital) attended the deceased from 11/14/1952 to 7/14/1961 , that (I) (we) last saw the deceased alive on July 14 19 61 , and that death occurred at 10:50 A.M. from the causes and on the date stated above. 22a. SIGNATURE V. Juerman M.D. 22c. PHYSICIAN'S NAME (Type) V. Juerman, M. D. 22b. DATE SIGNED 7/14/61 22d. ADDRESS Deer's Head State Hospital; Salisbury, Md. 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial 23b. DATE THEREOF 7/12/1961 23c. NAME OF CEMETERY OR CREMATORY Taylor's Island 23d. LOCATION (City, town or county) (State) Dorchester County, Md. 24. FUNERAL DIRECTOR'S SIGNATURE Herbert S. Leland Anthony E. Ward 25a. REC'D BY REGISTRAR JUL 18 '61 25b. REGISTRAR'S SIGNATURE Arthur S. Evans									

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CERTIFICATE OF DEATH

Reg. Dist. No. 08566

8572

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> b. CITY OR TOWN (If outside corporate limits, write rural and give nearest town) <u>SALISBURY</u> c. LENGTH OF STAY IN b <u>3 Weeks</u> d. NAME OF HOSPITAL (If not in hospital, give street address) OF INSTITUTION <u>Peninsula General Hospital</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) ✓ a. STATE <u>DELAWARE</u> b. COUNTY <u>SUSSEX</u> c. CITY OR TOWN (If outside corporate limits, write rural and give nearest town) <u>DELMAR</u> d. STREET ADDRESS <u>RURAL 46X-3</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>MARGARET</u> First <u>Cummings</u> Middle Last 4. DATE OF DEATH <u>July 23</u> Month Day Year <u>1961</u>				5. SEX <u>FEMALE</u> 6. COLOR OR RACE <u>WHITE</u> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH <u>11-15-1909</u> 9. AGE (In years lost birthday) <u>51</u> yrs. 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>PRESSER</u> 11. BIRTHPLACE (State or foreign country) <u>NEW YORK</u> 12. CITIZEN OF WHAT COUNTRY? <u>USA.</u>			
13. FATHER'S NAME <u>FRANK HARRINGTON</u> 14. MOTHER'S MAIDEN NAME <u>UNKNOWN</u>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, unknown) <u>NO</u> 16. SOCIAL SECURITY NO. <u>165-07-4162</u> 17. INFORMANT <u>John Cummings Delmar</u> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarct, acute</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>4-20-61</u> DUE TO (c)				INTERVAL BETWEEN ONSET AND DEATH <u>4 weeks</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>6-18</u> , 19 <u>61</u> , to <u>7-23</u> , 19 <u>61</u> , that I last saw the deceased alive on <u>7-23</u> , 19 <u>61</u> , and that death occurred at <u>10 AM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Wilber R. Ellis Jr.</u> M.D. <u>Salisbury, DE.</u> 7-23-61				ADDRESS (Street, city or town, state) DATE SIGNED			
PHYSICIAN'S NAME (Type) <u>Wilber R. Ellis Jr.</u> <u>Salisbury, Maryland</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>7-26-61</u>		<u>Mount Olive</u>		<u>Delmar</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>W-S. Marmel Co - Delmar, DE.</u> ADDRESS				24a. REC'D BY REGISTRAR <u>Jul 25 '61</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur E. Thomas</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

2012

THIS IS TO CERTIFY THAT on the 10th day of May 1912 at the residence of the deceased, Mrs. Mary Ann Smith, in the County of ... State of ... died of ...

The deceased was born on the 15th day of ... 1840, at ... and was the wife of ...

The cause of death was ...

Witness my hand and the seal of the Registrar General at ... this 10th day of May 1912.

Registrar General

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VR A15 (4)
15M 9/60

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
CERTIFICATE OF DEATH									
1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Delaware b. COUNTY New Castle				
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Delmar			c. LENGTH OF STAY in lb 10 days		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Newark			d. STREET ADDRESS 95 Madison Drive	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 401 Elizabeth Street					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) First IDA Middle ELLEN Last CURTISS					4. DATE OF DEATH Month July Day 27th Year 19 61				
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 11-16-1900		9. AGE (In years last birthday) 60 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) At Home		10b. KIND OF BUSINESS OR INDUSTRY Home		11. BIRTHPLACE (County & State, or foreign country) Delmar, Md.			12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME Elmer LeCates					14. MOTHER'S MAIDEN NAME Laura Ann Ruark				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No			16. SOCIAL SECURITY NO. None		17. INFORMANT Address Paul Curtiss, 95 Madison Dr. Newark, Del.				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary thrombosis; shock DUE TO 420.1 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) arteriosclerosis of coronary arteries DUE TO (c)								INTERVAL BETWEEN ONSET AND DEATH 30 min. ?	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from 7/27 , 19 61 , to 7/27 , 19 61 , that (I) (we) last saw the deceased alive on 7/27 1961 , and that death occurred at 7/27 M, from the causes and on the date stated above.									
22a. SIGNATURE Ernest Larmore M.D.					ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 7/27/61		
22c. PHYSICIAN'S NAME (Type) DR. Ernest Larmore,					22d. ADDRESS Delmar, Del.				
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town or county) (State)			
Burial		7-31-61		Cathedral		Wilmington, Del.			
24. FUNERAL DIRECTOR'S SIGNATURE W.S. Marvel Co - Delmar, Del.					25a. REC'D BY REGISTRAR DATE JUL 31 '61		25b. REGISTRAR'S SIGNATURE Arthur S. Evans		

(M)

(I)

Washington

1933

IDA

Female White

Age 10 years

Color 100%

No

None

Defective

10 days

22

11-1-1930

Defect, 100%

100% defective

and for all 100% defective, 100%

Customs inspection, 100%

Customs inspection, 100%

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon poppers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8574

CERTIFICATE OF DEATH

Reg. Dist. No. 08568

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Wicomico</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>PENINSULA GENERAL Hospital</u>		d. STREET ADDRESS <u>1 107 Ashylon Ave</u>	
3. NAME OF DECEASED (Type or print) First <u>X PAMELA</u> Middle <u>RUTH</u> Last <u>DAVIS</u>		4. DATE OF DEATH 1:55 P.M. <u>July 19, 1961</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <u>WIDOWED</u> <input type="checkbox"/> <u>Baby</u> <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2:00 A.M. 7-19-61</u>
9. AGE (In years lost birthday) <u>0</u> yrs. <u>0</u> months <u>11</u> days <u>55</u> Min.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>	
11. BIRTHPLACE (State or foreign country) <u>Salisbury, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U S A</u>	
13. FATHER'S NAME <u>MR. ROLAND R. DAVIS</u>		14. MOTHER'S MAIDEN NAME <u>Ruth Ellen Davis</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <u>INFORMANT</u> <u>Mr. Roland Raymond Davis (Father)</u> <u>Salisbury, Maryland</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory Failure</u> <u>754.5</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Cardiac Decompensation</u> (c) <u>Congenital Heart Disease</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>INTERVAL BETWEEN ONSET AND DEATH</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) <u>N/A</u>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>N/A</u>	
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u>N/A</u> p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>N/A</u>		20f. (City or town) (County) (State) <u>N/A</u>	
21. I certify that I attended the deceased from <u>7/19</u> , 19 <u>61</u> , to <u>7/19</u> , 19 <u>61</u> , that I last saw the deceased alive on <u>7/19</u> , 19 <u>61</u> , and that death occurred at <u>1:55 p.m.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>William C. Morgan</u>		ADDRESS (Street, city or town, state) <u>Salisbury Md.</u>	
PHYSICIAN'S NAME (Type) <u>Dr. William C. Morgan</u>		DATE SIGNED <u>7/19/61</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial July 22, 1961 Spring Hill Memory Gardens-Salisbury, Maryland</u>		22b. DATE THEREOF	
22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <u>HOLLOWAY & COMPANY SALISBURY MARYLAND</u>		24a. REC'D BY REGISTRAR <u>JUL 24 '61</u>	
24b. REGISTRAR'S SIGNATURE <u>Charles E. Hume</u>			

2082192XV4

MEMORIAL OF DEATH

1917

M
C

St. Robert Hospital, St. Louis, Mo.

Robert H. [Name]
[Address]
[City, State]

William E. [Name]
[Address]
[City, State]

COPIES OF THIS MEMORIAL

M

I

8575

08563

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Wicomico</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Tyaskin</u>		c. LENGTH OF STAY IN 1b <u>Lifetime</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>1</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Will</u> First <u>Davis</u> Middle <u>Davis</u> Last		4. DATE OF DEATH <u>July 2</u> Month <u>1961</u> Year	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9/15/1881</u>
9. AGE (In years last birthday) <u>79</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Carpenter</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Ship Carpenter</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S.</u>	
13. FATHER'S NAME <u>Henry S. Davis</u>		14. MOTHER'S MAIDEN NAME <u>Annie Griffin</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>218-16-567</u>	
17. INFORMANT <u>Neva Davis, Tyaskin, Md.</u> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Ventricular fibrillation</u> <u>434.4</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>cardiac decompensation</u> DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH <u>4 days</u> <u>6 yrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) _____	
20c. TIME OF INJURY Month, Day, Year Hour o. m. _____ 19 p. m. _____		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that (I) (this hospital) attended the deceased from <u>March</u> 19 <u>61</u> , to <u>July 2</u> 19 <u>61</u> , that (I) (we) last saw the deceased alive on <u>June 30</u> , 19 <u>61</u> , and that death occurred at <u>4:55</u> P. M. from the causes and on the date stated above.			
22a. SIGNATURE <u>Barbara Hunt</u>		22b. DATE SIGNED <u>7/3/61</u>	
22c. PHYSICIAN'S NAME (Type) <u>Barbara Hunt</u>		22d. ADDRESS <u>hanticoke, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>7/4/61</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Tyaskin Cem.</u>		23d. LOCATION (City, town, or county) <u>Tyaskin, Maryland</u> (State) _____	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Arthur S. Tibbels</u> ADDRESS <u>Bivale, Md.</u>		25a. REC'D BY REGISTRAR <u>Arthur S. Tibbels</u> 25b. REGISTRAR'S SIGNATURE <u>Arthur S. Tibbels</u>	

CHURCH L.V.M.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8576

CERTIFICATE OF DEATH

Reg. Dist. No. 08570

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Worcester</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SALISBURY</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Pocomoke City</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>PENINSULA GENERAL HOSPITAL</u>		d. STREET ADDRESS <u>23X-2</u>	
3. NAME OF DECEASED (Type or print) First <u>Janice</u> Middle <u>Lynn</u> Last <u>Dix</u>		4. DATE OF DEATH Month <u>July</u> Day <u>19</u> Year <u>1961</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>NEGRO</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>7/2/61</u>
9. AGE (In years lost birthday) yrs. <u>17</u>		10. IF UNDER 1 YEAR Months <u>17</u> Days <u>17</u> Hours <u>17</u> Min. <u>17</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Infant</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Infant</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA.</u>	
13. FATHER'S NAME <u>Herman Corbin Dix, Jr.</u>		14. MOTHER'S MAIDEN NAME <u>Mary Matthews</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>INFORMANT</u> <u>Herman Dix, Jr. Pocomoke City, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>754.5</u> DUE TO <u>Congenital Heart Disease (Single Ventricle)</u> Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause lost. (b) DUE TO _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH <u>17 days</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____		20d. INJURY OCCURRED While <input type="checkbox"/> at work Nat while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I attended the deceased from <u>7/18</u> , 19 <u>61</u> , to <u>7/19</u> , 19 <u>61</u> , that I last saw the deceased alive on <u>7/19</u> , 19 <u>61</u> , and that death occurred at <u>7:15</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Arthur C. Kolls</u> M.D.		ADDRESS (Street, city or town, state) <u>Medical Center</u> DATE SIGNED <u>7/20/61</u>	
PHYSICIAN'S NAME (Type) <u>Salisbury Maryland</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>7-21-61</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Unionville Cem.</u>	22d. LOCATION (City, town, or county) (State) <u>Pocomoke City, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Edgar Wharton - New Church, Va.</u>		24a. REC'D BY REGISTRAR DATE <u>JUL 24 '61</u>	
		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hines</u>	

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Condensed! Heart Disease
(Simple Ventricles)

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

8577

08571

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Worcester			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury				c. LENGTH OF STAY IN 1b Since 5/8/61			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Pine Bluff State Hospital				d. STREET ADDRESS RFD #2			
3. NAME OF DECEASED (Type or print) First Charity Middle Bell Last Donoway				4. DATE OF DEATH Month July Day 24 Year 19 61			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 23, 1888		9. AGE (In years lost birthday) 73 yrs.	10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY -		11. BIRTHPLACE (State or foreign country) Lewes, Del.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME James Wilson				14. MOTHER'S MAIDEN NAME Margaret Wilson			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 218-20-2681		17. INFORMANT Mr. William H. Donoway (Husband) Berlin Records of Pine Bluff State Hospital Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Thrombosis 443X DUE TO Conditions, if any, which gave rise to immediate cause (c), stating the under-lying cause last. (b) Hypertensive cardiovascular disease DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH 1 month 10 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) a. Pulmonary Tuberculosis. b. Diabetes Mellitus.						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from May 8, 1961 to July 24, 1961 , that (I) (we) last saw the deceased alive on July 24, 1961 , and that death occurred at 1:28 P.M. from the causes and on the date stated above.							
22a. SIGNATURE <i>E. P. Ritchings</i>				M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE 7/24/61	
22c. PHYSICIAN'S NAME (Type) E. P. Ritchings				22d. ADDRESS Salisbury, Maryland			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF July 27, 1961		23c. NAME OF CEMETERY OR CREMATORY Wicomico Mem. Park		23d. LOCATION (City, town, or county) (State) Salisbury, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE HOLLOWAY & COMPANY				ADDRESS SALISBURY, MARYLAND		25a. REC'D BY REGISTRAR DATE JUL 25 '61	
				25b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i>			

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23X-2

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MEDICAL CERTIFICATION

CERTIFICATE OF DEATH

(M)

Warrant

Since 1911

How Hall

Call number

1000

(Continued)



1911

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

3579
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

08573

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Wicomico	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Salisbury		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Delmar	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Peninsula Gen. Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) WILLIAM JAMES ELLIS		4. DATE OF DEATH July 23, 1961	
5. SEX Male		6. COLOR OR RACE White	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Oct. 4, 1896	
9. AGE (In years last birthday) 64 yrs.		10. IF UNDER 1 YEAR Months 7 Days 23	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Salesman		12. BIRTHPLACE (County & State, or foreign country) Maryland	
13. FATHER'S NAME Riley Ellis		14. MOTHER'S MAIDEN NAME Della Townsend	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 213-16-7952	
17. INFORMANT Mamie Ellis		Address Delmar, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.0 DUE TO Coronary Thrombosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) Arteriosclerotic heart disease (c) 7 years ±		INTERVAL BETWEEN ONSET AND DEATH 1 hour	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 3/1 , 19 54 to death , 19 61 , that (I) (we) last saw the deceased alive on 7/20 , 19 61 , and that death occurred at 10:25 AM on 7/23/61 from the causes and on the date stated above.			
22a. SIGNATURE Ernest M. Larmore M.D.		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22d. ADDRESS Delmar, Del.	
22c. PHYSICIAN'S NAME (Type) Dr. Ernest Larmore,		22b. DATE SIGNED 7-4/61	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 7-25-61	
23c. NAME OF CEMETERY OR CREMATORY Libertytown		23d. LOCATION (City, town or county) (State) Libertytown, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE W.S. Marmel Co - Delmar, Del.		25a. REC'D BY REGISTRAR JUL 26 '61	
ADDRESS Delmar, Del.		25b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

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FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If a delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

MARYLAND STATE DEPARTMENT OF HEALTH			
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND			
8580		MEDICAL EXAMINER'S CERTIFICATE OF DEATH	
08574			
1. PLACE OF DEATH a. COUNTY Wicomico		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Wicomico	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury	
c. LENGTH OF STAY IN 1b		d. STREET ADDRESS Jersey Road Route # 2	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Peninsula General Hospital		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Columbus Boyd Farrington		4. DATE OF DEATH 7-1-61	
5. SEX M		6. COLOR OR RACE C	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> B. DATE OF BIRTH 38 yrs.		9. AGE (In years last birthday) 38	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Salvor		11. BIRTHPLACE (State or foreign country) Maryland	
10b. KIND OF BUSINESS OR INDUSTRY		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Boyd Farrington		14. MOTHER'S MAIDEN NAME Amy Bivans	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. Ida Farrington Jersey Road	
17. INFORMANT Ida Farrington		Address Jersey Road	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Fracture of cervical spine DUE TO 812X Conditions, if any, which gave rise to immediate cause (b) 812X (a), stating the underlying cause last. (c) 812X PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 812X		INTERVAL BETWEEN ONSET AND DEATH 1 hour	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) Struck by car while walking on road near home.	
20c. TIME OF INJURY Month, Day, Year 11:30 P.M. 6-30-61		20d. INJURY OCCURED <input checked="" type="checkbox"/> While <input type="checkbox"/> Not While <input type="checkbox"/> et work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Jersey Road		20f. (City or town) Salisbury, Wicomico, Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		21. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
ACTUAL SIGNATURE Earl L. Royer		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) Earl L. Royer, M.D.		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> 7-7-61	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF July 4, 1961	
22c. NAME OF CEMETERY OR CREMATORY Greenacres		22d. LOCATION (City, town, or country) Salisbury Md	
23. FUNERAL DIRECTOR Clinton F. Stewart		ADDRESS Salisbury Md	
24a. REC'D BY REGISTRAR JUL 17 '61		24b. REGISTRAR'S SIGNATURE Clinton F. Stewart	

THE STATE
DEPARTMENT



Missouri
St. Louis

Missouri
St. Louis

Missouri

St. Louis General Hospital

St. Louis General Hospital

St. Louis General Hospital

St. Louis General Hospital

St. Louis General Hospital

St. Louis General Hospital

St. Louis General Hospital

St. Louis General Hospital

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FOR STATE
HEALTH DEPT.

TO DEPT. OF HEALTH: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

MARYLAND STATE DEPARTMENT OF HEALTH											
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
1. PLACE OF DEATH a. COUNTY		Wicomico		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE		Maryland		b. COUNTY Wicomico	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)		Salisbury		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)		Siloam		Salisbury	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)		Peninsula General Hospital		First		d. STREET ADDRESS		Route # 1		RFD	
3. NAME OF DECEASED (Type or print)		Luther Wesley Ford		4. DATE OF DEATH		7-23-61		19		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
5. SEX		M		6. COLOR OR RACE		W		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH June 14, 1925	
9. AGE (In years last birthday)		36		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		Mechanic		10b. KIND OF BUSINESS OR INDUSTRY		Garage	
11. BIRTHPLACE (State or foreign country)		Maryland		12. CITIZEN OF WHAT COUNTRY?		U.S.		13. FATHER'S NAME		Ruric Ford	
14. MOTHER'S MAIDEN NAME		Maggie Bozman		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service)		no		16. SOCIAL SECURITY NO.		17. INFORMANT Mrs. Eva. Ford	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 581.0 DUE TO Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause last. DUE TO (c)		Fatty Degeneration of Liver		INTERVAL BETWEEN ONSET AND DEATH				19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)											
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)		(State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE		Earl L. Royer		M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
EXAMINER'S NAME (Type)		Earl L. Royer, M.D.		DATE SIGNED		7-25-61		22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF	
22c. NAME OF CEMETERY OR CREMATORY		Fairmount		22d. LOCATION (City, town, or country)		Fairmount, Maryland		23. FUNERAL DIRECTOR		ADDRESS	
23. FUNERAL DIRECTOR		James Hunnison		24a. REC'D BY REGISTRAR		JUL 28 '61		24b. REGISTRAR'S SIGNATURE		Arthur L. Krome	

MEDICAL CERTIFICATION

082

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7-22-51

WILLIAM L. ROY, JR.,
407 E. 10th Ave.,
St. Paul, Minn.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

8582

08576

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Wicomico</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>		c. LENGTH OF STAY IN 1b <u>10Yr. 12Days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Deer's Head State Hospital</u>				d. STREET ADDRESS <u>109 Brooklyn Avenue</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Helen</u> Middle <u>J.</u> Last <u>Foskey</u>				4. DATE OF DEATH Month <u>July</u> Day <u>24</u> Year <u>1961</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>August 23, 1894</u>	9. AGE (In years last birthday) <u>66</u> yrs.	IF UNDER 1 YEAR Months <u> </u> Days <u> </u>	IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>
10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Whitesville, Del.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>			
13. FATHER'S NAME <u>None</u>				14. MOTHER'S MAIDEN NAME <u>Levinia Foskey</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT <u>Hospital Records -- Salisbury, Maryland</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis</u> 332X DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>Generalized Arterio Sclerosis</u> (e), stating the underlying cause last. DUE TO (c) <u>1 day</u> <u>10 yrs</u>				INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Rheumatoid Arthritis</u>				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20c. TIME OF INJURY Hour e.m. <u> </u> p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>7/12/61</u> to <u>7/24/61</u> , 19 <u>61</u> , that (I) (we) last saw the deceased alive on <u>7/24/61</u> , 19 <u>61</u> , and that death occurred at <u>6:10</u> M, from the causes and on the date stated above.							
22a. SIGNATURE <u>Lee L. Lawry</u>				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>7-24-61</u>	
22c. PHYSICIAN'S NAME (Type) <u>Lee L. Lawry, M.D.</u>				22d. ADDRESS <u>Deer's Head Hospital -- Salisbury, Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>7-26-61</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Laurel Hill</u>		23d. LOCATION (City, town or county) (State) <u>Laurel, Delaware</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>W. S. Marvel Co - Seilmor, Del</u>				25a. REC'D BY REGISTRAR DATE <u>JUL 28 '61</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur L. Frank</u>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. (Page 4 may be retained by the hospital or attending physician.)
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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15M 9/60



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*Revised Thomson
Universal Cutter 1/2*

Rhumatoid Cutter

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Lee Harvey

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8583

CERTIFICATE OF DEATH

Reg. Dist. No.

08577

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Wicomico</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u> 12			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Peninsula General</u>				d. STREET ADDRESS <u>155 Fooks St.</u> 1			
3. NAME OF DECEASED (Type or print) First Middle Last <u>OLLIE SELBY</u>				4. DATE OF DEATH Month Day Year <u>July 7 1961</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 12, 1895</u>	9. AGE (In years last birthday) yrs. <u>65</u>	IF UNDER 1 YEAR Months <u>11</u> Days <u>25</u>	IF UNDER 24 HRS. Hours <u></u> Min. <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House Painter</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Painting</u>		11. BIRTHPLACE (State or foreign country) <u>Pittsville, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U S A</u>	
13. FATHER'S NAME <u>Levi German</u>				14. MOTHER'S MAIDEN NAME <u>Olevia Dennis</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u></u>		INFORMANT Address <u>Mrs Marcie L. German (Wife) 115 Fooks St Salisbury, Maryland</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) DUE TO						INTERVAL BETWEEN ONSET AND DEATH <u>6 mo.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)				
21. I certify that I attended the deceased from <u>Sept 7</u> , 19 <u>60</u> , to <u>7</u> , 19 <u>61</u> , that I last saw the deceased alive on <u>7/7</u> , 19 <u>61</u> , and that death occurred at <u>4:30 PM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>F. R. Gramse</u>				ADDRESS (Street, city or town, state) DATE SIGNED <u>Salisbury, Md.</u> <u>7/7/61</u>			
PHYSICIAN'S NAME (Type) <u>Dr. Fred R. Gramse</u>				S. Division St. Salisbury, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>July 10, 1961</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Parsons Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Salisbury, Maryland</u>				
23. FUNERAL DIRECTOR'S SIGNATURE <u>HOLLOWAY & COMPANY</u>		ADDRESS <u>SALISBURY MARYLAND</u>		24a. REC'D BY REGISTRAR DATE <u>Jul 11 '61</u>	24b. REGISTRAR'S SIGNATURE <u>Carlton L. Kline</u>		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



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JUL 10 1961

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CUT OFF DATE ON ORDER

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UNITED STATES

JUL 10 1961

HOUSE OF REPRESENTATIVES

WASHINGTON, D.C.

OFFICE OF THE CLERK

OFFICE OF THE CLERK

THE HOUSE OF REPRESENTATIVES

THE HOUSE OF REPRESENTATIVES

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 08578

2584

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u> c. LENGTH OF STAY IN 1b <u>12</u> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Peninsular General Hosp.</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Wicomico</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u> d. STREET ADDRESS <u>204 Washington St.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Minnie Mae Harmon</u>				4. DATE OF DEATH Month Day Year <u>July 19 1961</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>MAY 14-1884</u>	
9. AGE (In years last birthday) <u>77</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House Work at Home</u>		11. BIRTHPLACE (State or foreign country) <u>Wicomico Co. Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U S A</u>	
13. FATHER'S NAME <u>Jacob Hastings</u>				14. MOTHER'S MAIDEN NAME <u>Sallie Cordrey</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>INFORMANT</u> <u>Miss Katharyn Harmon (Daughter) 204 Wash- ington St. Salisbury, Maryland</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bronchopneumonia Superimposed</u> 434.1 DUE TO <u>on intractable congestive heart failure</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>5 days</u> DUE TO (c) <u>generalized arteriosclerosis, pyelonephritis</u>							INTERVAL BETWEEN ONSET AND DEATH <u>7 hours</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>generalized arteriosclerosis, pyelonephritis</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) <u>N/A</u>		20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>N/A</u> 19 <u>19</u> p. m. <u>N/A</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Nat while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>N/A</u>		20f. (City or town) <u>N/A</u>		(County) <u>N/A</u>		(State) <u>N/A</u>	
21. I certify that I attended the deceased from <u>July 13, 1961</u> , to <u>July 19, 1961</u> , that I last saw the deceased alive on <u>July 18, 1961</u> , and that death occurred at <u>12:25 PM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Salisbury, Maryland</u> DATE SIGNED <u>July 19, 1961</u>							
ACTUAL SIGNATURE <u>Robert T. Adkins</u> M.D.				PHYSICIAN'S NAME (Type) <u>Dr. Robert T. Adkins</u> <u>Fruitland, Maryland</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>July 20, 1961</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Parsons Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Salisbury, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>HOLLOWAY & COMPANY</u> ADDRESS <u>SALISBURY MARYLAND</u>				24a. REC'D BY REGISTRAR DATE <u>JUL 24 '61</u>		24b. REGISTRAR'S SIGNATURE <u>Charles S. Adams</u>	

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FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If a delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the Funeral Director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

MEDICAL CERTIFICATION

1. PLACE OF DEATH				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)			
a. COUNTY				a. STATE			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)				b. COUNTY			
c. LENGTH OF STAY IN TB				c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)				d. STREET ADDRESS			
1. PLACE OF DEATH				2. USUAL RESIDENCE			
a. COUNTY				a. STATE			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)				b. COUNTY			
c. LENGTH OF STAY IN TB				c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)				d. STREET ADDRESS			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print)				4. DATE OF DEATH			
First Middle Last				Month Day Year			
5. SEX				6. COLOR OR RACE			
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				8. DATE OF BIRTH			
9. AGE (in years last birthday)				IF UNDER 1 YEAR Months Days			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY			
11. BIRTHPLACE (State or foreign country)				12. CITIZEN OF WHAT COUNTRY?			
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.			
17. INFORMANT				Address			
18. CAUSE OF DEATH (Enter only one cause per line, for (a), (b), and (c).)				Interval between ONSET AND DEATH			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)				DUE TO			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.				(b)			
DUE TO				(c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
ACTUAL SIGNATURE				M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type)				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify)				22b. DATE THEREOF			
22c. NAME OF CEMETERY OR CREMATORY				22d. LOCATION (City, town, or country) (State)			
23. FUNERAL DIRECTOR				24a. REC'D BY REGISTRAR			
ADDRESS				24b. REGISTRAR'S SIGNATURE			

1. PLACE OF DEATH a. COUNTY b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) c. LENGTH OF STAY IN TB d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)

2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE b. COUNTY c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) d. STREET ADDRESS

3. NAME OF DECEASED (Type or print) 4. DATE OF DEATH Month Day Year

5. SEX 6. COLOR OR RACE 7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐ 8. DATE OF BIRTH

9. AGE (in years last birthday) 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) 10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country) 12. CITIZEN OF WHAT COUNTRY? 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) 16. SOCIAL SECURITY NO. 17. INFORMANT

18. CAUSE OF DEATH (Enter only one cause per line, for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (b)

DUE TO (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m.

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐ Inspection ☒ Inquiry ☒ and in my opinion death resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

CHIEF MEDICAL EXAMINER ☐

ACTUAL SIGNATURE M.D. ASSISTANT MEDICAL EXAMINER ☐

EXAMINER'S NAME (Type) DEPUTY MEDICAL EXAMINER ☒

22a. BURIAL, CREMATION, REMOVAL (Specify) 22b. DATE THEREOF

22c. NAME OF CEMETERY OR CREMATORY 22d. LOCATION (City, town, or country) (State)

23. FUNERAL DIRECTOR ADDRESS 24a. REC'D BY REGISTRAR

24b. REGISTRAR'S SIGNATURE

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8585

CERTIFICATE OF DEATH

Reg. Dist. No.

08580

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>WICOMICO</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>				c. LENGTH OF STAY IN 1b <u>7 hrs.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Peninsula General Hospital</u>				d. STREET ADDRESS <u>RFD #1</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last <u>JULIA ANN Hastings</u>				4. DATE OF DEATH Month Day Year <u>July 1 1961</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>6-17-1895</u>	
9. AGE (In years last birthday) <u>66</u> yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>at Home</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>		11. BIRTHPLACE (State or foreign country) <u>Delmar, Del</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>							
13. FATHER'S NAME <u>Thos. Orlifant</u>				14. MOTHER'S MAIDEN NAME <u>Unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u>221-07-2366</u>			
17. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>587.0</u> DUE TO <u>acute hemorrhage Pancreas</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>4 days</u> DUE TO (c) <u></u>				INTERVAL BETWEEN ONSET AND DEATH <u>4 days</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>July 1</u> , 19 <u>61</u> , to <u></u> , 19 <u></u> , that I last saw the deceased alive on <u>July 1</u> , 19 <u>61</u> , and that death occurred at <u>9:50 P.M.</u> , from the causes and on the date stated above.							
ADDRESS (Street, city or town, state) <u>Delmar, Del</u>							
DATE SIGNED <u>7-3-61</u>							
ACTUAL SIGNATURE <u>William S. Ellis</u> M.D.							
PHYSICIAN'S NAME (Type) <u>W. S. Ellis</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF <u>7-4-61</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Delmar Del</u>		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <u>W. S. Ellis</u>		ADDRESS <u>Delmar Del</u>		24a. REC'D BY REGISTRAR <u>JUL 5 '61</u>		24b. REGISTRAR'S SIGNATURE <u>Charles S. Evans</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

(M)

Washington

May 10, 1918

Dear Sir:

Dear Sir:

Dear Sir:

Dear Sir:

Dear Sir:

Dear Sir:

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH
08581

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) (Rural) Parsonsburg				c. LENGTH OF STAY IN 1b X Parsonsburg (Rural)			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION R.D.#				d. STREET ADDRESS R.D.#		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) WALLACE H. HOLLOWAY				4. DATE OF DEATH Month JULY Day 25th Year 1961			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Oct. 20, 1893	
9. AGE (In years lost birthday) 67 yrs.		10. IF UNDER 1 YEAR Months 6 Days 18 Hours 15 Min.		11. IF UNDER 24 HRS. Months 6 Days 18 Hours 15 Min.		12. CITIZEN OF WHAT COUNTRY? U S A	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer & Poultry Grower				10b. KIND OF BUSINESS OR INDUSTRY R.D.# Parsonsburg, Md			
11. BIRTHPLACE (State or foreign country) R.D.# Parsonsburg, Md				12. CITIZEN OF WHAT COUNTRY? U S A			
13. FATHER'S NAME Handy B. Holloway				14. MOTHER'S MAIDEN NAME Iva C. Perdue			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. U. S. ARMY			
17. INFORMANT Mrs Katie J. Holloway (Wife)				18. ADDRESS Parsonsburg, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion DUE TO 420.1 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) arteriosclerosis DUE TO hypertension (c) hypertension						INTERVAL BETWEEN ONSET AND DEATH 2-3 hours	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) N/A			
20c. TIME OF INJURY Month, Day, Year Hour o. m. N/A 19 p. m. N/A		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) N/A		20f. (City or town) (County) (State) N/A	
21. I certify that (I) (this hospital) attended the deceased from 7-21-61 to 7-25 , 1961, that (I) (we) last saw the deceased alive on 7-25 , 1961, and that death occurred at 5:30 P.M. from the causes and on the date stated above.							
22a. SIGNATURE Frank Lewis				22b. DATE July 27, 1961		22c. PHYSICIAN'S NAME (Type) Dr. Frank R. Lewis	
22d. ADDRESS Willards, Maryland				22e. ADDRESS Willards, Maryland			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF July 29, 1961		23c. NAME OF CEMETERY OR CREMATORY Forest Grove Cem.		23d. LOCATION (City, town, or county) (State) R.D.# Parsonsburg, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE HOLLOWAY & COMPANY				25a. REC'D BY REGISTRAR Salisbury, Maryland		25b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

CERTIFICATE OF DEATH

287

(Print Name)

(Print Name)

(Print Name)

(Print Name)

(Print Name)

(Print Name)

(Print Name)

(Print Name)

(Print Name)

(Print Name)

(Print Name)

(Print Name)

(Print Name)

(Print Name)

(Print Name)

(Print Name)

(Print Name)

(Print Name)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

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MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
8588											
08582											
1. PLACE OF DEATH a. COUNTY Wicomico b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury, Maryland c. LENGTH OF STAY IN 1b 1 mo. 13 days d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Deer's Head State Hospital						2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury, Maryland d. STREET ADDRESS 401 Isabella St. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) Phillip First Middle Last Horseman						4. DATE OF DEATH Month Day Year July 1 19 61					
5. SEX Male		6. COLOR OR RACE W		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 5/2/1885		9. AGE (In years last birthday) 76 yrs.		IF UNDER 1 YEAR Months Days 1	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Perry A. Norman						14. MOTHER'S MAIDEN NAME Emily					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) yes						16. SOCIAL SECURITY NO. 01-337213					
17. INFORMANT Luke Horseman						Address Salisbury, Md.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (e) Pulmonary Emphysema 527.1 DUE TO Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) Generalized Arteriosclerosis INTERVAL BETWEEN ONSET AND DEATH 5 yrs											
MEDICAL CERTIFICATION 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) May 18, 19 61 to July 1, 19 61 6:45P											
21. I certify that (I) (this hospital) attended the deceased from May 18, 19 61 to July 1, 19 61 , that (I) (we) last saw the deceased alive on July 1, 19 61 , and that death occurred at 6:45P , from the causes and on the date stated above.											
22a. SIGNATURE Lee L. Larry M.D. 22c. PHYSICIAN'S NAME (Type) Lee L. Larry, M.D.						ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> 22d. ADDRESS Salisbury, Maryland 22b. DATE SIGNED 7-1-61					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE THEREOF 7/4/61		23c. NAME OF CEMETERY OR CREMATORY Birchview Cem.		23d. LOCATION (City, town or county) (State) Birchview, Md.			
24. GENERAL DIRECTOR'S SIGNATURE C. D. Messick						ADDRESS Baltimore Md.		25a. REC'D BY REGISTRAR DATE JUL 6 '61		25b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

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[Faint, mostly illegible handwritten text, possibly bleed-through from the reverse side of the page. Some words like "I have" and "the" are faintly visible.]

CERTIFICATE OF DEATH

Reg. Dist. No.

08583

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>SOMERSET</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>		c. LENGTH OF STAY IN 1b <u>4 days</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Memorial General</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>John</u> Middle <u>PERRY</u> Last <u>HORSEY</u>		4. DATE OF DEATH Month <u>7</u> Day <u>10</u> Year <u>1961</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>JAN. 9, 1881</u>
9. AGE (In years last birthday) <u>80</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>LABORER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>SEAFOOD</u>	
11. BIRTHPLACE (State or foreign country) <u>MARION MD.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>John Perry Horsey</u>		14. MOTHER'S MAIDEN NAME <u>Lucy Whittington</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>220-12071</u>	
17. INFORMANT <u>Ada M. Horsey</u> Address <u>Crisfield Md.</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary Edema</u> 434-1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Chronic Congestive Heart Failure</u> DUE TO (c) <u>3 Days</u> <u>4 months</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> at work Nat while <input type="checkbox"/> at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>July 6</u> , 19 <u>61</u> , to <u>July 10</u> , 19 <u>61</u> , that I last saw the deceased alive on <u>July 10</u> , 19 <u>61</u> , and that death occurred at <u>9:10 P.</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>George H. Henning</u> M.D. <u>Salisbury, Md.</u>		DATE SIGNED <u>7/10/61</u>	
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>July 14, 1961</u>		22b. DATE THEREOF	
22c. NAME OF CEMETERY OR CREMATORY <u>MT. PEAR (MARION MD)</u>		22d. LOCATION (City, town, or county) (State) <u>MARION STATION Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Anthony E. Ward</u> ADDRESS <u>11 1/2 S. 4th ST, Crisfield Md.</u>		24a. REC'D BY REGISTRAR DATE <u>JUL 13 '61</u>	
24b. REGISTRAR'S SIGNATURE <u>Anthony E. Ward</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

STATE OF NEW YORK
IN SENATE
January 10, 1881.
REPORT
OF THE
COMMISSIONER OF DEATH
AND
VITAL STATISTICS
FOR THE YEAR
1880.
ALBANY:
J. B. LIPPINCOTT & CO. PRINTERS.
1881.

CERTIFICATE OF DEATH

Reg. Dist. No.

08584

8590

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>WICOMICO</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>		c. LENGTH OF STAY IN 1b <u>2 weeks</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>DELMAR</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Peninsula General Hospital</u>				d. STREET ADDRESS <u>1411 CHESTNUT</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>OLLIE</u> Middle <u>Johnson</u> Last <u>Johnson</u>				4. DATE OF DEATH Month <u>7</u> Day <u>30</u> Year <u>1961</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>8-3-1878</u>	
9. AGE (In years last birthday) <u>82</u> yrs.		IF UNDER 1 YEAR Months <u>82</u> Days <u>82</u> Hours <u>82</u> Min. <u>82</u>		IF UNDER 24 HRS. Months <u>82</u> Days <u>82</u> Hours <u>82</u> Min. <u>82</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>TRAINMAN</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>RAILROAD</u>		11. BIRTHPLACE (State or foreign country) <u>DELAWARE</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>GEORGE W. JOHNSON</u>				14. MOTHER'S MAIDEN NAME <u>EMMA HARRIS</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>716-01-6893</u>		INFORMANT <u>Clara Johnson - Delmar, Md.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of prostate</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Prostatic carcinoma</u> DUE TO (c) _____				INTERVAL BETWEEN ONSET AND DEATH <u>Unknown</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I attended the deceased from _____, 19 <u>61</u> , to <u>7-30</u> , 19 <u>61</u> , that I last saw the deceased alive on <u>7-30</u> , 19 <u>61</u> , and that death occurred at <u>5:40 PM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>William H. Fisher</u> M.D.				ADDRESS (Street, city or town, state) <u>Salisbury, Md.</u> DATE SIGNED <u>8-1-61</u>			
PHYSICIAN'S NAME (Type) <u>William H. Fisher</u>				<u>Salisbury, Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>8-2-61</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Bridgetown</u>		22d. LOCATION (City, town, or county) (State) <u>Bridgetown, Del.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>W.S. Marvel Co - Delmar, Del.</u>				24a. REC'D BY REGISTRAR DATE <u>AUG 3</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Thomas</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 2 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

M

State of New York

County of ...

City of ...

DECEASED

NAME

AGE

SEX

DATE OF DEATH

PLACE OF DEATH

Cause of Death

Signature of Physician

Signature of Registrar

Signature of Coroner

Signature of ...

Signature of ...

Signature of ...

Signature of ...

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

8591

08585

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Somerset			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury				c. LENGTH OF STAY IN 1b 297 days			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Deer's Head State Hospital				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Princess Anne, Maryland			
3. NAME OF DECEASED (Type or print) Harry Jones				4. DATE OF DEATH Month July Day 29 Year 19 61			
5. SEX Male		6. COLOR OR RACE Colored		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH II/9/1885	
9. AGE (In years last birthday) 75 yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Machinist				10b. KIND OF BUSINESS OR INDUSTRY Automobile		11. BIRTHPLACE (County & State, or foreign country) Princess Anne, Md	
12. CITIZEN OF WHAT COUNTRY? U S A							
13. FATHER'S NAME Henry C. Jones				14. MOTHER'S MAIDEN NAME Matilda Smith			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)				16. SOCIAL SECURITY NO.			
17. INFORMANT Henry C. Jones Jr. Princess Anne, Md				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 157X IMMEDIATE CAUSE (a) Carcinoma of Prostate DUE TO (b) 5 yrs. Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Oct. 5 , 19 60 , to July 29 , 19 61 , that (I) (we) last saw the deceased alive on July 29 , 19 61 , and that death occurred at 7:45 P.M. from the causes and on the date stated above.							
22a. SIGNATURE Lee L. Lawry				ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED 7/29/61	
22c. PHYSICIAN'S NAME (Type) Lee L. Lawry, M. D.				22d. ADDRESS Deer's Head State Hospital; Salisbury, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 8/2/61		23c. NAME OF CEMETERY OR CREMATORY John Wesley		23d. LOCATION (City, town or county) (State) Princess Anne, Md	
24. FUNERAL DIRECTOR'S SIGNATURE William H. James Jr				25a. REC'D BY REGISTRAR DATE AUG 3 '61		25b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

M

1933

Winchester

21st Street

1933

Winchester, Mass., England

There is a small house located at

Henry

John

July

1933

Male

Colon

1933

1933

Henry J. Jones

1

Caracas / Rote

Lucy Jones

Box 1, New York, N.Y.

Oct. 2

July 1933

x

During last year (1932)...

8592

CERTIFICATE OF DEATH

Reg. Dist. No.

08586

1. PLACE OF DEATH a. COUNTY <u>Wicomico Co</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>Wicomico Co</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury, MD</u>				c. LENGTH OF STAY IN 1b <u>2 Days</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Peninsula General Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>LINWOOD W. Kehly</u>				4. DATE OF DEATH Month Day Year <u>July 15 1961</u>			
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>1/22/1895</u>	
9. AGE (In years (last birthday) <u>66</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>POLICE OFFICER D.C. POLICE</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>POLICE</u>			
13. FATHER'S NAME <u>JAMES KELLY</u>				14. MOTHER'S MAIDEN NAME <u>VICTORIA HOWETH</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>				16. SOCIAL SECURITY NO. <u>578-44-2785-MRS LINWOOD KELLY</u>			
17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Artery Thrombosis</u> 420 <u>✓</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>7 hrs.</u> DUE TO (c) <u>INTERVAL BETWEEN ONSET AND DEATH</u>				18. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> at work Nat while <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				21. I certify that I attended the deceased from <u>7/14</u> , 19 <u>61</u> , to <u>7/15</u> , 19 <u>61</u> , that I last saw the deceased alive on <u>7/14</u> , 19 <u>61</u> , and that death occurred at <u>1:04</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>David J. [Signature]</u> M.D.				ADDRESS (Street, city or town, state) <u>Salisbury Md.</u> DATE SIGNED <u>7/15/61</u>			
PHYSICIAN'S NAME (Type) <u>LECOMPT FURNERAL SERVICE</u>				22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>			
22b. DATE THEREOF <u>7/17/61</u>				22c. NAME OF CEMETERY OR CREMATORY <u>DORCHESTER MEM PARK</u>			
22d. LOCATION (City, town, or county) (State) <u>CAMBRIDGE MD</u>				23. REGISTRAR'S SIGNATURE <u>Arthur L. [Signature]</u>			
24. REC'D BY REGISTRAR <u>JUL 28 '61</u>				24b. REGISTRAR'S SIGNATURE <u>Arthur L. [Signature]</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1
The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO HOSPITAL OR ATTENDING PHYSICIAN: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
8593				Item 7 Film G290 7/20/61 ink				08587			
1. PLACE OF DEATH				2. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)							
a. COUNTY				e. STATE				b. COUNTY			
Wicomico				Maryland				Wicomico			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)				c. LENGTH OF STAY IN 1b				c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)			
Salisbury				15 yrs.				Salisbury			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)				d. STREET ADDRESS				a. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
Peninsula Gen. Hosp.											
3. NAME OF DECEASED (Type or print)				4. DATE OF DEATH				Month Day Year			
Mack				Kirkland				7 2 1961			
5. SEX		6. COLOR OR RACE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH		9. AGE (In years last birthday)		IF UNDER 1 YEAR	
M		AA		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		Not Known		59 yrs.		Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (County & State, or foreign country)			
Laborer				Farm				Alabama			
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME				12. CITIZEN OF WHAT COUNTRY?			
Not Known				Not Known				USA			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service)				16. SOCIAL SECURITY NO.				17. INFORMANT			
No				265 18 5906				Mrs. Maggie Kirkland, Salisbury, Md			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)				INTERVAL BETWEEN ONSET AND DEATH							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)				Cerebral Thrombosis				Sudden			
443X DUE TO				Hypertensive Cardiovascular				3 years			
Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last.				Hypertension Atherosclerosis				Unk			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY				20d. INJURY OCCURRED				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
Month, Day, Year				While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>				20f. (City or town) (County) (State)			
Hour a.m. p.m.				19							
21. I certify that (I) (this hospital) attended the deceased from June 26, 1961, to July 2, 1961; that (I) (we) last saw the deceased alive on June 30, 1961, and that death occurred at 7:30 P.M. from the causes and on the date stated above.											
22a. SIGNATURE				22b. DATE				22c. PHYSICIAN'S NAME (Type)			
G. Herbert Sembly				July 8, 1961				G. Herbert Sembly, M.D.			
22d. ADDRESS				22e. REC'D BY REGISTRAR				22f. REGISTRAR'S SIGNATURE			
400 East Church Street, Salisbury, Md.				DATE JUL 13 '61				Arthur L. Kline			
23a. BURIAL, CREMATION, REMOVAL (Specify)				23b. DATE THEREOF				23c. NAME OF CEMETERY OR CREMATORY			
Burial				7/8/61				Bivens Cem			
23d. LOCATION (City, town or county) (State)				23e. REC'D BY REGISTRAR				23f. REGISTRAR'S SIGNATURE			
Nr. Allen, Md.				DATE JUL 13 '61				Arthur L. Kline			
24. FUNERAL DIRECTOR'S SIGNATURE				24b. ADDRESS				24c. DATE			
Theraten B. Jolley				Salisbury, Md							

VR A15 (4)
15M 9/60

8583



Robert Smith, M.D.

Chicago, Ill.

8594

CERTIFICATE OF DEATH

Reg. Dist. No. 08588

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MARYLAND</u> b. COUNTY <u>Worcester</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>				c. LENGTH OF STAY IN 1b <u>md</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Peninsula General Hosp.</u>				d. STREET ADDRESS <u>Route 3 23X-2</u>			
3. NAME OF DECEASED (Type or print) First <u>Robert</u> Middle <u>Lee</u> Last <u>MAPP</u>				4. DATE OF DEATH Month <u>July</u> Day <u>10</u> Year <u>1961</u>			
5. SEX <u>male</u>	6. COLOR OR RACE <u>negro</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct. 20, 1902</u>	9. AGE (In years lost birth day) yrs. <u>38</u>	IF UNDER 1 YEAR Months <u> </u> Days <u> </u>	IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>	e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farm Work</u>		11. BIRTHPLACE (State or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John H. Mapp</u>				14. MOTHER'S MAIDEN NAME <u>Tincie Stratton</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		INFORMANT Address <u>Laura Allen Pocomoke City, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause lost. (b) <u> </u> DUE TO (c) <u> </u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Arteriosclerosis due to Nephrosclerosis</u>							INTERVAL BETWEEN ONSET AND DEATH <u>16 days</u>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u> </u> p. m. <u> </u> 19 <u>61</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>6/24</u> , 19 <u>61</u> , to <u>7/10</u> , 19 <u>61</u> , that I last saw the deceased alive on <u>7/10/61</u> , 19 <u>61</u> , and that death occurred at <u>11:15</u> A. M., from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>David J. Gilmore</u> M.D.				ADDRESS (Street, city or town, state) DATE SIGNED <u>Salisbury, Md July 10, 1961</u>			
PHYSICIAN'S NAME (Type) <u>David J. Gilmore</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>7-16-61</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Accomac Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Accomac, Va.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Samuel Savage</u>				ADDRESS <u>New Church, Va.</u>		24a. REC'D BY REGISTRAR DATE <u>JUL 17 '61</u>	
				24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kneiss</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copy. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1923

No. _____

Decedent's Name _____

Age _____ Sex _____

Place of Birth _____

Residence _____

Occupation _____

Married _____

Signature of Physician _____

Death _____

Signature of Registrar _____

CERTIFICATE OF DEATH

Reg. Dist. No. 08589

8595

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MARYLAND</u> b. COUNTY <u>Worcester</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Snow Hill</u>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Peninsula General Hospital</u>			d. STREET ADDRESS <u>112 W. Federal Street</u>		
3. NAME OF DECEASED (Type or print) First Middle Last <u>Walter Thaddeus MASON</u>			4. DATE OF DEATH Month Day Year <u>July 13 1961</u>		
5. SEX <u>Male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct 26 1878</u>		9. AGE (In years last birthday) <u>82 1/2</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Mechanic</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Vanity Store</u>		11. BIRTHPLACE (State or foreign country) <u>Snow Hill, Md</u>	
12. CITIZEN OF WHAT COUNTRY?			13. FATHER'S NAME <u>Stephen E. Mason</u>		
14. MOTHER'S MAIDEN NAME <u>Ellen Silchard</u>			15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		
16. SOCIAL SECURITY NO. <u>None</u>			17. INFORMANT Address <u>Mrs. Stula N. Mason, Snow Hill, Md</u>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebrovascular Accident</u> 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerosis & heart disease</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Chronic bronchitis and pulmonary emphysema - Cerebral Prolate</u>					
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW DEATH OCCURRED (Enter nature of injury in Part I or Part II of item 18.) <u>Transurethral prostatectomy for urinary tract obstruction</u> 5 July 61			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		(County)		(State)	
21. I certify that I attended the deceased from <u>27 June</u> , 19 <u>61</u> , to <u>13 July</u> , 19 <u>61</u> , that I last saw the deceased alive on <u>13 July</u> , 19 <u>61</u> , and that death occurred at <u>8:50</u> A.M., from the causes and on the date stated above.					
ADDRESS (Street, city or town, state)					
DATE SIGNED					
ACTUAL SIGNATURE <u>Joseph C. Fitzgerald</u> M.D.					
PHYSICIAN'S NAME (Type) _____					
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>July 13/61</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Episcopal Cemetery</u>	
22d. LOCATION (City, town, or county) <u>Snow Hill, Md</u>		(State)			
23. FUNERAL DIRECTOR'S SIGNATURE <u>Wayne E. Dimes</u>		ADDRESS <u>Snow Hill, Md</u>		24a. REC'D BY REGISTRAR DATE <u>JUL 17 '61</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur L. Hume</u>					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

2232

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
8596											
CERTIFICATE OF DEATH											
Item 8 Film G292 8/1/61 jwk											
08590											
1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> <u>MARYLAND</u>						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Kent</u>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>						c. LENGTH OF STAY IN lb <u>33 days</u>					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Deer's Head State Hospital</u>						c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chestertown,</u>					
						d. STREET ADDRESS <u>110 Prospect Street</u>					
3. NAME OF DECEASED (Type or print) First <u>James</u> Middle <u>MAYNOR</u> Last <u>MAYNOR</u>						4. DATE OF DEATH Month <u>July</u> Day <u>25</u> Year <u>1961</u>					
5. SEX <u>Male</u>		6. COLOR OR RACE <u>Colored</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>4/6/1884 1883</u>		9. AGE (In years last birthday) <u>78</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Various</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Florida</u>		12. CITIZEN OF WHAT COUNTRY <u>unknown</u>		13. FATHER'S NAME <u>Gilbert Maynor</u> <u>unknown</u>		14. MOTHER'S MAIDEN NAME <u>unknown</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>107-14-7483</u>		17. INFORMANT <u>Luvienur Maynor</u>		Address <u>Chestertown, Md.</u>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Recurrent cerebral thrombosis</u> <u>332X</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>Arteriosclerosis, general</u> (a), stating the underlying cause last. DUE TO (c) <u> </u>		INTERVAL BETWEEN ONSET AND DEATH <u>18 days</u> <u>Years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Hour a.m. <u> </u> p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)		(State)	
21. I certify that (I) (this hospital) attended the deceased from <u>June 22, 1961</u> to <u>July 25, 1961</u> , that (I) (we) last saw the deceased alive on <u>July 25, 1961</u> , and that death occurred at <u>7 P.M.</u> from the causes and on the date stated above.											
22a. SIGNATURE <u>V. Juerman</u> M.D.						ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED <u>7/25/61</u>			
22c. PHYSICIAN'S NAME (Type) <u>V. Juerman, M. D.</u>						22d. ADDRESS <u>Deer's Head Hospital; Salisbury, Md.</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>7/29/61</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Pomona Cemetery</u>		23d. LOCATION (City, town or county) <u>Near - Chestertown, Md.</u>		(State)			
24. FUNERAL DIRECTOR'S SIGNATURE <u>Benneth Wesley</u>						ADDRESS <u>Chestertown, Md.</u>		25a. REC'D BY REGISTRAR DATE <u>JUL 28 '61</u>		25b. REGISTRAR'S SIGNATURE <u>Carlton S. Hanna</u>	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 08591

8597

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>WORCESTER</u> ✓			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>				c. LENGTH OF STAY IN TB		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BERLIN</u> <u>23X-2</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>082 Peninsula General</u>				d. STREET ADDRESS <u>MAIN ST</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Lillian</u> Middle <u>Mae</u> Last <u>Melton</u>				4. DATE OF DEATH Month <u>JULY</u> Day <u>19</u> Year <u>1961</u>			
5. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>JUNE 17, 1888</u>	
9. AGE (In years last birthday) <u>73</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u>		IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>OWN HOME</u>		11. BIRTHPLACE (State or foreign country) <u>BERLIN MD</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>							
13. FATHER'S NAME <u>MELVIN</u>				14. MOTHER'S MAIDEN NAME <u>ELIZABETH BRADFORD</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u> </u> (If yes, give war or dates of service) <u> </u>				16. SOCIAL SECURITY NO. <u> </u> INFORMANT <u> </u> Address <u> </u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Renal Failure</u> 704 <u> </u> DUE TO <u> </u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic cardiovascular disease</u> DUE TO <u> </u> (c) <u>Pemphigus Vulgaris suspected</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Encephalomalacia</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour <u> </u> a. m. <u> </u> p. m. <u> </u> 19 <u> </u>				20d. INJURY OCCURRED While <input type="checkbox"/> at work Nat while <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>	
20f. (City or town) <u> </u> (County) <u> </u> (State) <u> </u>							
21. I certify that I attended the deceased from <u>7-15</u> , 19 <u>61</u> to <u>7/19</u> , 19 <u>61</u> , that I last saw the deceased alive on <u>7/19/61</u> , 19 <u> </u> , and that death occurred at <u>3:20 AM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u> </u> DATE SIGNED <u> </u>							
ACTUAL SIGNATURE <u>Joseph C. Fitzgerald</u> M.D. <u> </u>							
PHYSICIAN'S NAME (Type) <u> </u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>7/21/61</u>		22c. NAME OF CEMETERY OR CREMATORY <u>RIVERSIDE CEM.</u>		22d. LOCATION (City, town, or county) <u>BERLIN (RFD) MD.</u> (State) <u>MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Anna A. Burboye</u> ADDRESS <u>Berlin Md</u>				24a. REC'D BY REGISTRAR <u>JUL 24 '61</u> DATE <u> </u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Thomas</u>	

117-05046-2 20-37 451-473 484-499 500-515 516-531 532-547 548-563 564-579 580-595 596-611 612-627 628-643 644-659 660-675 676-691 692-707 708-723 724-739 740-755 756-771 772-787 788-803 804-819 820-835 836-851 852-867 868-883 884-899 900-915 916-931 932-947 948-963 964-979 980-995 996-1011 1012-1027 1028-1043 1044-1059 1060-1075 1076-1091 1092-1107 1108-1123 1124-1139 1140-1155 1156-1171 1172-1187 1188-1203 1204-1219 1220-1235 1236-1251 1252-1267 1268-1283 1284-1299 1300-1315 1316-1331 1332-1347 1348-1363 1364-1379 1380-1395 1396-1411 1412-1427 1428-1443 1444-1459 1460-1475 1476-1491 1492-1507 1508-1523 1524-1539 1540-1555 1556-1571 1572-1587 1588-1603 1604-1619 1620-1635 1636-1651 1652-1667 1668-1683 1684-1699 1700-1715 1716-1731 1732-1747 1748-1763 1764-1779 1780-1795 1796-1811 1812-1827 1828-1843 1844-1859 1860-1875 1876-1891 1892-1907 1908-1923 1924-1939 1940-1955 1956-1971 1972-1987 1988-2003 2004-2019 2020-2035 2036-2051 2052-2067 2068-2083 2084-2099 2100-2115 2116-2131 2132-2147 2148-2163 2164-2179 2180-2195 2196-2211 2212-2227 2228-2243 2244-2259 2260-2275 2276-2291 2292-2307 2308-2323 2324-2339 2340-2355 2356-2371 2372-2387 2388-2403 2404-2419 2420-2435 2436-2451 2452-2467 2468-2483 2484-2499 2500-2515 2516-2531 2532-2547 2548-2563 2564-2579 2580-2595 2596-2611 2612-2627 2628-2643 2644-2659 2660-2675 2676-2691 2692-2707 2708-2723 2724-2739 2740-2755 2756-2771 2772-2787 2788-2803 2804-2819 2820-2835 2836-2851 2852-2867 2868-2883 2884-2899 2900-2915 2916-2931 2932-2947 2948-2963 2964-2979 2980-2995 2996-3011 3012-3027 3028-3043 3044-3059 3060-3075 3076-3091 3092-3107 3108-3123 3124-3139 3140-3155 3156-3171 3172-3187 3188-3203 3204-3219 3220-3235 3236-3251 3252-3267 3268-3283 3284-3299 3300-3315 3316-3331 3332-3347 3348-3363 3364-3379 3380-3395 3396-3411 3412-3427 3428-3443 3444-3459 3460-3475 3476-3491 3492-3507 3508-3523 3524-3539 3540-3555 3556-3571 3572-3587 3588-3603 3604-3619 3620-3635 3636-3651 3652-3667 3668-3683 3684-3699 3700-3715 3716-3731 3732-3747 3748-3763 3764-3779 3780-3795 3796-3811 3812-3827 3828-3843 3844-3859 3860-3875 3876-3891 3892-3907 3908-3923 3924-3939 3940-3955 3956-3971 3972-3987 3988-4003 4004-4019 4020-4035 4036-4051 4052-4067 4068-4083 4084-4099 4100-4115 4116-4131 4132-4147 4148-4163 4164-4179 4180-4195 4196-4211 4212-4227 4228-4243 4244-4259 4260-4275 4276-4291 4292-4307 4308-4323 4324-4339 4340-4355 4356-4371 4372-4387 4388-4403 4404-4419 4420-4435 4436-4451 4452-4467 4468-4483 4484-4499 4500-4515 4516-4531 4532-4547 4548-4563 4564-4579 4580-4595 4596-4611 4612-4627 4628-4643 4644-4659 4660-4675 4676-4691 4692-4707 4708-4723 4724-4739 4740-4755 4756-4771 4772-4787 4788-4803 4804-4819 4820-4835 4836-4851 4852-4867 4868-4883 4884-4899 4900-4915 4916-4931 4932-4947 4948-4963 4964-4979 4980-4995 4996-5011 5012-5027 5028-5043 5044-5059 5060-5075 5076-5091 5092-5107 5108-5123 5124-5139 5140-5155 5156-5171 5172-5187 5188-5203 5204-5219 5220-5235 5236-5251 5252-5267 5268-5283 5284-5299 5300-5315 5316-5331 5332-5347 5348-5363 5364-5379 5380-5395 5396-5411 5412-5427 5428-5443 5444-5459 5460-5475 5476-5491 5492-5507 5508-5523 5524-5539 5540-5555 5556-5571 5572-5587 5588-5603 5604-5619 5620-5635 5636-5651 5652-5667 5668-5683 5684-5699 5700-5715 5716-5731 5732-5747 5748-5763 5764-5779 5780-5795 5796-5811 5812-5827 5828-5843 5844-5859 5860-5875 5876-5891 5892-5907 5908-5923 5924-5939 5940-5955 5956-5971 5972-5987 5988-6003 6004-6019 6020-6035 6036-6051 6052-6067 6068-6083 6084-6099 6100-6115 6116-6131 6132-6147 6148-6163 6164-6179 6180-6195 6196-6211 6212-6227 6228-6243 6244-6259 6260-6275 6276-6291 6292-6307 6308-6323 6324-6339 6340-6355 6356-6371 6372-6387 6388-6403 6404-6419 6420-6435 6436-6451 6452-6467 6468-6483 6484-6499 6500-6515 6516-6531 6532-6547 6548-6563 6564-6579 6580-6595 6596-6611 6612-6627 6628-6643 6644-6659 6660-6675 6676-6691 6692-6707 6708-6723 6724-6739 6740-6755 6756-6771 6772-6787 6788-6803 6804-6819 6820-6835 6836-6851 6852-6867 6868-6883 6884-6899 6900-6915 6916-6931 6932-6947 6948-6963 6964-6979 6980-6995 6996-7011 7012-7027 7028-7043 7044-7059 7060-7075 7076-7091 709

1
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If a delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Tyaskin		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Tyaskin	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Home		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Delcie		4. DATE OF DEATH 7-13-61	
5. SEX F W		6. COLOR OR RACE W	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 10/8/1882	
9. AGE (In years last birthday) 78		10. IF UNDER 1 YEAR Months Days	
11. IF UNDER 24 HRS. Hours Min.		12. CITIZEN OF WHAT COUNTRY? V.S.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Unemployed		10b. KIND OF BUSINESS OR INDUSTRY -	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? V.S.	
13. FATHER'S NAME John L. Royer		14. MOTHER'S MAIDEN NAME Clara V. Roberts	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) -		16. SOCIAL SECURITY NO. -	
17. INFORMANT Martin Messick		Address Salisbury	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion DUE TO Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. (b) Arterio-sclerotic heart disease- DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.			
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Earl L. Royer, M.D.		DATE SIGNED 7-13-61	
EXAMINER'S NAME (Type) Earl L. Royer, M.D.		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7/15/61	
22c. NAME OF CEMETERY OR CREMATORY Tyaskin Cem.		22d. LOCATION (City, town, or country) (State) Tyaskin, Maryland	
23. FUNERAL DIRECTOR Wm. J. Bivak, Jr.		24a. REC'D BY REGISTRAR DATE JUL 17 '61	
24b. REGISTRAR'S SIGNATURE Arthur L. Kraus			

MEDICAL CERTIFICATION

1
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

1
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08593

1. PLACE OF DEATH a. COUNTY Wicomico		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Wicomico	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fruitland	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Peninsula General Hospital		d. STREET ADDRESS Bruce St.	
3. NAME OF DECEASED (Type or print) First Middle Last Isaac Harrison Mills		4. DATE OF DEATH Month Day Year 7-8-61	
5. SEX M	6. COLOR OR RACE C	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2-22-1938
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		9. AGE (In years last birthday) 23	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME Edmund Mills		14. MOTHER'S MAIDEN NAME Annie Turpin	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 19	
17. INFORMANT Wife: Mrs. Peggy Mills, Fruitland, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hemorrhage due to DUE TO (b) Bullet wound of back Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		INTERVAL BETWEEN ONSET AND DEATH 3 hours	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Shot during a quarrel.	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 12:30 a.m. 7-8-61	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home	20f. (City or town) (County) (State) Fruitland Wicomico Md.
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Earl L. Royer		DATE SIGNED 7-13-61	
EXAMINER'S NAME (Type) Earl L. Royer, M.D.		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7-11-61	
22c. NAME OF CEMETERY OR CREMATORY Mt. Zion Cemetery		22d. LOCATION (City, town, or country) (State) Polks Road Maryland	
23. FUNERAL DIRECTOR Thornton B. Jolley, Salisbury, Md.		24a. REC'D BY REGISTRAR DATE JUL 18 '61	
		24b. REGISTRAR'S SIGNATURE Arthur S. House	

MEDICAL CERTIFICATION



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8600

CERTIFICATE OF DEATH

Reg. Dist. No. 08594

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Wicomico</u>			
b. CITY OR TOWN (If outside corporate limits, write Rural and give nearest town) <u>Salisbury</u>				c. CITY OR TOWN (If outside corporate limits, write Rural and give nearest town) <u>Bivalve</u>			
c. LENGTH OF STAY IN 1b <u>18 Days</u>				d. STREET ADDRESS <u>1</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Peninsula General Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>John Finlay Neilson</u>				4. DATE OF DEATH Month Day Year <u>July 30 1961</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>6-27-1887</u>	
9. AGE (In years, lost birthday) <u>74</u> yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Breker</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Ins.</u>		11. BIRTHPLACE (State or foreign country) <u>NY.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U. S.</u>							
13. FATHER'S NAME <u>John F. Neilson</u>				14. MOTHER'S MAIDEN NAME <u>Agusta Emmeluth</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u>-</u>			
17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Chronic glomerular Nephritis</u> DUE TO <u>592X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>17</u> DUE TO (c)				INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>7-30</u> , 19 <u>61</u> , to <u>7-30</u> , 19 <u>61</u> , that I last saw the deceased alive on <u>7-30</u> , 19 <u>61</u> , and that death occurred at <u>10 PM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Richard A. Insley</u>				ADDRESS (Street, city or town, state) <u>Salisbury Md 7-31-61</u>			
DATE SIGNED							
PHYSICIAN'S NAME (Type) <u>Ph. L. P. A. Insley</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF <u>8/2/61</u>		22c. NAME OF CEMETERY OR CREMATORY <u>White Plains Rural Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>White Plains, NY.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Arthur S. Kraus</u>				ADDRESS <u>Bivalve, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>AUG 2 '61</u>	
24b. REGISTRAR'S SIGNATURE							

CERTIFICATE OF DEATH

600

Winnipeg

1202-1203

General Hospital

1000

John F. Hollister

Chronic Bronchitis

1915-1916

1917-1918

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

1

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

8601

CERTIFICATE OF DEATH

08595

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Queen Anne's	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Salisbury		c. LENGTH OF STAY IN 1b 24 days	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Deer's Head State Hospital		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Chester	
d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Jerry Nickerson		4. DATE OF DEATH Month July Day 14 Year 19 61	
5. SEX Male	6. COLOR OR RACE Colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 8, 1894
9. AGE (In years last birthday) 66 yrs.		IF UNDER 1 YEAR Months 6 Days 14 Hours 19 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Domestic	
11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Unknown		16. SOCIAL SECURITY NO. Unknown	
17. INFORMANT Unknown		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary edema DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic cardiovascular disease DUE TO (c) Nephrosclerosis PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) Nephrosclerosis			
INTERVAL BETWEEN ONSET AND DEATH 10 minutes			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from June 20, 1961 to July 14, 1961 , that (I) (we) last saw the deceased alive on July 13, 1961 , and that death occurred at 6:15 A.M. from the causes and on the date stated above.			
22a. SIGNATURE V. Juerman		22b. DATE SIGNED 7/14/61	
22c. PHYSICIAN'S NAME (Type) V. Juerman, M. D.		22d. ADDRESS Deer's Head State Hospital; Salisbury, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF July 18, 1961	
23c. NAME OF CEMETERY OR CREMATORY Chester Cem.		23d. LOCATION (City, town or county) (State) Chester Md.	
24. FUNERAL DIRECTOR'S SIGNATURE James B. Washburn		25a. REC'D BY REGISTRAR DATE JUL 19 '61	
25b. REGISTRAR'S SIGNATURE Arthur L. Frank			

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8602

CERTIFICATE OF DEATH

Reg. Dist. No. 08596

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Wicomico</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>		c. LENGTH OF STAY IN 1b <u>12 MRS.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Peninsula General</u>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>MAJOR LEE PHILLIPS</u>		4. DATE OF DEATH Month Day Year <u>July 10 1961</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>6-4-1881</u>
9. AGE (In years last birthday) <u>80</u>		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Owner</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Major Lemuel Phillips</u>		14. MOTHER'S MAIDEN NAME <u>Belle Wimbrow</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>None</u>	
INFORMANT Address <u>Mr. Walter L. Phillips, Salisbury, Maryland</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>422.2 Pulmonary Edema</u> DUE TO (b) <u>Degenerative Heart disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Bronchopneumonia, Diabetes mellitus</u>			INTERVAL BETWEEN ONSET AND DEATH <u>14 hours</u> <u>?</u>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>MAY</u> , 19 <u>61</u> , to <u>July 10</u> , 19 <u>61</u> , that I lost the deceased alive on <u>July 9</u> , 19 <u>61</u> , and that death occurred at <u>2:45</u> P.M., from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Robert T. Adkins</u> M.D.		ADDRESS (Street, city or town, state) <u>Fruitland, Maryland</u> DATE SIGNED <u>July 10, 1961</u>	
PHYSICIAN'S NAME (Type) <u>Dr. Robert T. Adkins Fruitland, Maryland</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>7-12-61</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Parsons Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Salisbury, Maryland</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Hill & Johnson Co. Salisbury, Maryland</u> ADDRESS		24a. REC'D BY REGISTRAR <u>JUL 13 '61</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur L. Kraw</u>

1

28

CERTIFICATE OF DEATH

1902

(M)

(1)

NAME

AGE

SEX

Usual Residence

Usual Residence

Usual Residence

Place of Death

Place of Death

Time

Dr. Robert L. Phillips, Physician

Dr. Robert L. Phillips, Physician

Dr. Robert L. Phillips, Physician

Dr. Robert L. Phillips, Physician

Dr. Robert L. Phillips, Physician

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Dr. Robert L. Phillips, Physician

Dr. Robert L. Phillips, Physician

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

8603

08597

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Wicomico			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hebron				c. LENGTH OF STAY IN 1b X Hebron			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Walnut St				d. STREET ADDRESS Walnut St		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last WILMER WASHINGTON PHILLIPS				4. DATE OF DEATH Month Day Year JULY 12TH 19 61			
5. SEX Male	6. COLOR OR RACE White	7. <input checked="" type="checkbox"/> MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH April 1, 1886		9. AGE (In years lost birthday) 75 yrs.	IF UNDER 1 YEAR Months 3 Days 11
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Watchman(Packing Co.)		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Worcester Co. Maryland		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME Albert Phillips				14. MOTHER'S MAIDEN NAME Ella Wilkins			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT Address Mrs. Augusta Phillips (Wife) Walnut St Hebron, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hemorrhage, middle cerebral artery 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause lost. (b) Arteriosclerotic Heart Disease (c) Arteriosclerosis, generalized							INTERVAL BETWEEN ONSET AND DEATH 0 10 yrs 10 yrs
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) N/A					
20c. TIME OF INJURY Month, Day, Year Hour o. m. N/A 19 p. m.		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) N/A		20f. (City or town) (County) (State) N/A	
21. I certify that (I) (the hospital) attended the deceased from 28 May 1961 to 12 July 1961 , that (I) (the) last saw the deceased alive on 12 July 1961 , and that death occurred at 8:40 A.M. from the causes and on the date stated above.							
22a. SIGNATURE Dr. George G. Schlesinger				22b. DATE SIGNED July 14 - 1961		22c. PHYSICIAN'S NAME (Type) Dr. George G. Schlesinger	
22d. ADDRESS Mardela, Maryland		22e. ADDRESS Mardela, Maryland					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF July 14, 1961		23c. NAME OF CEMETERY OR CREMATORY Union Cemetery		23d. LOCATION (City, town, or county) (State) R.D.# Salisbury, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE HOLLOWAY & COMPANY				25a. REC'D BY REGISTRAR JUL 17 '61		25b. REGISTRAR'S SIGNATURE Charles E. Kiser	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 08593

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) o. STATE Maryland b. COUNTY Wicomico			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury				c. LENGTH OF STAY IN 1b Hrs.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) A Eden	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Peninsula Gen. Hospital				d. STREET ADDRESS RFD#2		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Ulysses Middle S. A. Last Polk, Sr.				4. DATE OF DEATH Month July Day 29 Year 19 61			
5. SEX Male		6. COLOR OR RACE AA		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Aug. 2, 1896	
9. AGE (In years last birthday) 64 yrs.		IF UNDER 1 YEAR Months 64 Days 0 Hours 0 Min. 0		IF UNDER 24 HRS. Hours 0 Min. 0			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter				10b. KIND OF BUSINESS OR INDUSTRY Building		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME Thomas E. Polk, Sr.				14. MOTHER'S MAIDEN NAME Alice King			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) [If yes, give war or dates of service] No				16. SOCIAL SECURITY NO.		17. INFORMANT Ulysses S. A. Polk, Jr. Eden, Md. Rt #2	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute congestive heart failure DUE TO (b) Arteriosclerotic heart disease DUE TO (c) 420-8 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE Ph. L. A. Insley M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) Ph. L. A. Insley				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 8 2 61		22c. NAME OF CEMETERY OR CREMATORY Friendship Cem.		22d. LOCATION (City, town, or county) (State) Allen, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Thornton B. Jolley				ADDRESS Salisbury, Md.		24a. REC'D BY REGISTRAR DATE AUG 8 '61	
						24b. REGISTRAR'S SIGNATURE Arthur L. Kline	

MEDICAL CERTIFICATION

TO DEPT. OF HEALTH: This certificate should be executed within 24 hours after death. If any other certificate is necessary, please execute this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item Id. Film G290 7/17/61 iwk

3605

CERTIFICATE OF DEATH

Reg. Dist. No. 02599

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Worcester</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>				c. LENGTH OF STAY IN 1b <u>mins.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Peninsula General Hospital</u>				d. STREET ADDRESS <u>23X-2</u>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Charles H. Purnell</u>				4. DATE OF DEATH Month Day Year <u>July 3, 1961</u> 19 <u>61</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>Colored</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <u>WIDOWED</u> <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>July, 3, 1891</u>	
9. AGE (In years last birthday) <u>70</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farming</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Joshua Fassett</u>				14. MOTHER'S MAIDEN NAME <u>Maggie Purnell</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> (If yes, give war or dates of service) <u>W.W.I</u>				16. SOCIAL SECURITY NO. <u>218-20-6858</u>		17. INFORMANT Address <u>Margaret Purnell, Selbyvill</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hypertensive Cardiovascular Disease</u> DUE TO (c) <u>Stroke</u>				INTERVAL BETWEEN ONSET AND DEATH <u>1 hour</u> <u>4 yrs</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>1-19-57</u> to <u>7/3-1961</u> , that I last saw the deceased alive on <u>7-3-1961</u> , and that death occurred at <u>11:45 AM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Berlin, Md.</u> DATE SIGNED <u>7/5/61</u>							
ACTUAL SIGNATURE <u>Henry A. Sullivan, Jr. MD</u>				PHYSICIAN'S NAME (Type) <u>Ivory A. Sullivan, Jr. MD</u> <u>Berlin Md</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>7-9-61</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Evergreen Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Berlin Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Henry A. Watson</u> <u>Pocomoke City, Md.</u>				24a. REC'D BY REGISTRAR DATE <u>JUL 10 61</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Frank</u>	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE 18

1
8605
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH
08600

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Worcester	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. LENGTH OF STAY IN 1b Adm-7/1/61	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Pen Gen Hosp		d. STREET ADDRESS #8 S.Division St	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First OLGA Middle HARRIETT Last ROGONE		4. DATE OF DEATH Month JULY Day 5th Year 1961	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 11, 1898
9. AGE (In years last birthday) 62 yrs.		10. IF UNDER 1 YEAR Months 11 Days 24	11. IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Work- Retired		10b. KIND OF BUSINESS OR INDUSTRY School Teacher	
11. BIRTHPLACE (State or foreign country) New York City, N.Y.		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME Fredrick Hoyer		14. MOTHER'S MAIDEN NAME Anna Mackau	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 	
17. INFORMANT Mr Joseph A. Rogone (Husband)		Address #8 S.Division St. Ocean City, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Metastatic adenocarcinoma to liver and brain DUE TO (b) Adenocarcinoma of colon DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.		INTERVAL BETWEEN ONSET AND DEATH 3 weeks 6 months	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) N/A	
20c. TIME OF INJURY Month, Day, Year Hour o. m. N/A p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) N/A		20f. (City or town) N/A (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 7-2-1961 to 7-5-1961 , that (I) (we) last saw the deceased alive on 7-5-1961 , and that death occurred at 2:30 A.M. from the causes and on the date stated above.			
22a. SIGNATURE William R. Ellis Jr		22b. DATE SIGNED July 5/1961	
22c. PHYSICIAN'S NAME (Type) Dr. Wilbar R. Ellis Jr		22d. ADDRESS Medical Center Salisbury, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF July 8, 1961	
23c. NAME OF CEMETERY OR CREMATORY Bay View Cemetery		23d. LOCATION (City, town, or county) (State) Bayonne, New Jersey	
24. FUNERAL DIRECTOR'S SIGNATURE HOLLOWAY & COMPANY		ADDRESS SALISBURY, MARYLAND	
25a. REC'D BY REGISTRAR JUL 7 '61		25b. REGISTRAR'S SIGNATURE Arthur S. Thomas	

(M)

(I)

MADE IN U.S.
BOX CO. 100
CHICAGO ILL.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 8 Film G291 7/24/61 iwk

CERTIFICATE OF DEATH

Reg. Dist. No. 08601

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u> c. LENGTH OF STAY IN 1b		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Wicomico</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u> d. STREET ADDRESS <u>Leena Ave</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Shawell</u>		4. DATE OF DEATH Month Day Year <u>July 7 1961</u>			
5. SEX <u>Female colored</u>	6. COLOR OR RACE <u>colored</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>7 7 61</u>	9. AGE (In years, lost birthday) yrs. <u>7</u> Months <u>7</u> Days <u>8</u> Hours <u>8</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Salisbury md</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>Robert Shawell</u>		14. MOTHER'S MAIDEN NAME <u>Betty Waller</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>+</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>—</u>		INFORMANT Address <u>Robert Shawell</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Immaturity (Birth Wt 685gms)</u> 776X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					
18a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		18b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20a. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While o. m. Not while o. m. <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)					
21. I certify that I attended the deceased from <u>7/7</u> , 19 <u>61</u> , to <u>7/7</u> , 19 <u>61</u> , that I last saw the deceased alive on <u>7/7</u> , 19 <u>61</u> , and that death occurred at <u>10:55</u> AM, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Medical Center</u> DATE SIGNED <u>7/7/61</u>					
ACTUAL SIGNATURE <u>Alfred C. Collins</u> M.D.		PHYSICIAN'S NAME (Type) <u>Salisbury, Maryland</u>			
22a. BURIAL, CREMATION, or REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>7-18-61</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Glenn Hill Cem</u>	
22d. LOCATION (City, town, or county) (State) <u>Personnaburg, md</u>		24a. REC'D BY REGISTRAR DATE <u>JUL 17 '61</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hines</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Burton M. West</u>		ADDRESS			

2082214XV0

CERTIFICATE OF DEATH

11/12

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1. Name of deceased

2. Sex

3. Age

4. Date of birth

5. Place of birth

6. Date of death

7. Cause of death

8. Place of death

9. Signature of physician

10. Signature of registrar

11. Signature of informant

12. Date of registration

13. Place of registration

14. Signature of registrar

15. Date of registration

16. Place of registration

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH

8608

08602

1. PLACE OF DEATH e. COUNTY Wicomico MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) e. STATE Maryland b. COUNTY Wicomico			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. LENGTH OF STAY IN lb 13 Mos		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		d. STREET ADDRESS Patrick Avenue	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Patrick Avenue				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Rebecca Smith		First Middle		4. DATE OF DEATH 7 17 19 61		Month Day Year	
5. SEX FM	6. COLOR OR RACE AA	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3 15 1881	9. AGE (In years last birthday) 80 yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House wife		10b. KIND OF BUSINESS OR INDUSTRY Home		11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME John Powell				14. MOTHER'S MAIDEN NAME Hennie Powell			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) No				16. SOCIAL SECURITY NO. 17. INFORMANT Mrs. Dora Nutter, Patrick Ave., Salisbury, Md			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) Degenerative Heart Disease (c) Arterio Sclerosis				INTERVAL BETWEEN ONSET AND DEATH Indefinite Indefinite			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a):							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour e.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Feb. 1961 to July 1961 , that (I) (we) last saw the deceased alive on July 6, 1961 , and that death occurred at 1:30 PM from the causes and on the date stated above.							
22a. SIGNATURE E. A. Purnell				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) E. A. Purnell MD				22d. ADDRESS 657 West Main Street, Salisbury, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 7 23 1961		23c. NAME OF CEMETERY OR CREMATORY Mt. Zion Cem.		23d. LOCATION (City, town or county) (State) Polks Road, Md. Sem. County	
24. FUNERAL DIRECTOR'S SIGNATURE Thernton B. Jelley, Salisbury, Md.				25a. REC'D BY REGISTRAR JUL 25 '61		25b. REGISTRAR'S SIGNATURE Arthur L. Kraus	

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• Indikator = Zeichen für die Erreichung eines Ziels

UNCLASSIFIED



203



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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BP

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
CERTIFICATE OF DEATH									
3610									
08604									
1. PLACE OF DEATH a. COUNTY Wicomico b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury, Maryland c. LENGTH OF STAY IN 1b 3 days d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Deer's Head State Hospital					2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Kent c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Millington, Md. d. STREET ADDRESS 14X-2 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>				
3. NAME OF DECEASED (Type or print) First Ruth Middle Mae Last Smith					4. DATE OF DEATH Month July Day 22 Year 19 61				
5. SEX Female		6. COLOR OR RACE C		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 12-5-25		9. AGE (In years last birthday) 35 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) Masony Kent Co. Md.		12. CITIZEN OF WHAT COUNTRY U.S.A	
13. FATHER'S NAME ?				14. MOTHER'S MAIDEN NAME Jessie Jones					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)				16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT Address Hospital Records			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of right breast 170X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, lectory, street, office bldg., etc.) 20f. (City or town) (County) (State)								INTERVAL BETWEEN ONSET AND DEATH 8 month	
21. I certify that (I) (this hospital) attended the deceased from July 19, 1961 , to July 22, 1961 , that (I) (we) last saw the deceased alive on July 22, 1961 , and that death occurred at 10:35 PM from the causes and on the date stated above.								19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
22a. SIGNATURE Dr. V. Juerman 22c. PHYSICIAN'S NAME (Type) V. Juerman, M.D.					22b. DATE SIGNED July 23, 1961 22d. ADDRESS Salisbury, Maryland				
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF July, 26, 1961		23c. NAME OF CEMETERY OR CREMATORY New Bethel Cemetery		23d. LOCATION (City, town or county) Golt, (State) Md.			
24. FUNERAL DIRECTOR'S SIGNATURE Edward Fellows 25a. REC'D BY REGISTRAR JUL 27 '61 25b. REGISTRAR'S SIGNATURE Arthur S. Hanks				ADDRESS Millington, Md.					

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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
8611
CERTIFICATE OF DEATH
08605

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Wicomico			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Pen Gen Hosp				d. STREET ADDRESS 528 Washington St			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First HERBERT Middle GLEN Last STURGIS		4. DATE OF DEATH Month JULY Day 5th Year 19 61					
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH Oct. 22, 1905	9. AGE (In years last birthday) yrs. 55	IF UNDER 1 YEAR Months Days 	IF UNDER 24 HRS. Hours Min. 	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Taxi Operator & Owner		10b. KIND OF BUSINESS OR INDUSTRY TAXI		11. BIRTHPLACE (State or foreign country) Powellville, Maryland		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME Herbert C. Sturgis				14. MOTHER'S MAIDEN NAME Emma M. Parker			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Unk		16. SOCIAL SECURITY NO. 		17. INFORMANT Mr. Russell G. Sturgis (Son) Address 528 Washington Street Salisbury, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Broncho pneumonia 151X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Generalized carcinoma of DUE TO (c) Adeno carcinoma of stomach							INTERVAL BETWEEN ONSET AND DEATH 2 days months year
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) N/A		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) N/A					
20c. TIME OF INJURY Month, Day, Year Hour o. m. N/A 19 p. m. 		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) N/A		20f. (City or town) (County) (State) N/A	
21. I certify that (I) (this hospital) attended the deceased from 1955 19 7-5 19 61 , that (I) (we) last saw the deceased alive on 7-5 19 61 , and that death occurred at 4:30 PM , from the causes and on the date stated above.							
22a. SIGNATURE Earl L. Royer				22b. DATE July 7 1961		22c. PHYSICIAN'S NAME (Type) Dr. Earl L. Royer	
22d. ADDRESS 407 Camden Ave. Salisbury, Maryland							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF July 8, 1961		23c. NAME OF CEMETERY OR CREMATORY St. Johns Cemetery		23d. LOCATION (City, town, or county) (State) Powellville, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE HOLLOWAY & COMPANY				ADDRESS SALISBURY, MARYLAND		25a. REC'D BY REGISTRAR DATE JUL 11 '61	
				25b. REGISTRAR'S SIGNATURE Arthur S. Thomas			

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82

CERTIFICATE OF DEATH

Reg. Dist. No.

08606

8612

1. PLACE OF DEATH

a. COUNTY

Wicomico

MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Salisbury

c. LENGTH OF STAY IN 1b

1 Day

2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission)

o. STATE

b. COUNTY

2nd Worcester

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Shiloh

d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION

Peninsula General Hospital

d. STREET ADDRESS

23X-2

e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print)

First

Middle

Last

Mary Taylor

4. DATE OF DEATH

Month

Day

Year

July 21 1961

5. SEX

Female

6. COLOR OR RACE

Negro

7. MARRIED ☐ NEVER MARRIED ☐WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH

June 19 - 1875

9. AGE (In years last birthday)

84 1/2

IF UNDER 1 YEAR

Months Days Hours Min.

IF UNDER 24 HRS.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Housewife

10b. KIND OF BUSINESS OR INDUSTRY

Housewife

11. BIRTHPLACE (State or foreign country)

Shiloh, Md

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

Zadok Collier

14. MOTHER'S MAIDEN NAME

Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)

No

16. SOCIAL SECURITY NO. (If yes, give war or dates of service)

None

INFORMANT

Address

Matis Taylor, Shiloh, Md

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)

DUE TO

Degenerative Heart Disease

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b)

DUE TO

Atherosclerosis

(c)

INTERVAL BETWEEN ONSET AND DEATH

Indefinite

Indefinite

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m.

20d. INJURY OCCURRED While ☐ Not while ☐ of work ☐ at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that I attended the deceased from 20 July, 1961, to 21 July, 1961, that I last saw the deceased alive on 21 July, 1961, and that death occurred at 3:45 P.M. from the causes and on the date stated above.

ACTUAL SIGNATURE

E. A. Turner

M.D.

ADDRESS (Street, city or town, state)

652 W. Main Salisbury, Md

DATE SIGNED

22 July 61

PHYSICIAN'S NAME (Type)

E. A. TURNER II

Salisbury Md

22a. BURIAL, CREMATION, REMOVAL (Specify)

22b. DATE THEREOF

22c. NAME OF CEMETERY OR CREMATORY

22d. LOCATION (City, town, or county)

(State)

23. FUNERAL DIRECTOR'S SIGNATURE

ADDRESS

24a. REC'D BY REGISTRAR

24b. REGISTRAR'S SIGNATURE

DATE

JUL 26 '61

C. E. Turner

LETTER FROM

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W. H. H. H.

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CERTIFICATE OF DEATH

Reg. Dist. No. 08607

8613

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>WICOMICO</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>		c. LENGTH OF STAY IN 1b <u>5 weeks</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Delmar</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Peninsula General</u>				d. STREET ADDRESS <u>407 Maryland Ave</u>			
3. NAME OF DECEASED (Type or print) First <u>George</u> Middle <u>A</u> Last <u>Templeton</u>				4. DATE OF DEATH Month <u>7</u> Day <u>26</u> Year <u>1961</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>1-30-1882</u>	
9. AGE (In years last birthday) <u>79</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Foreman</u>		11. BIRTHPLACE (State or foreign country) <u>ENGLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>JOHN E. TEMPLETON</u>				14. MOTHER'S MAIDEN NAME <u>ELIZABETH BROWN</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>716-01-7154</u>		17. INFORMANT <u>Rena Templeton - Delmar Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Septicemia</u> DUE TO <u>610X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>urinary tract infection</u> DUE TO <u>Benign Prostatic Enlargement</u> (c) <u>centenarian</u>							INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u> <u>2 day</u> <u>centenarian</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> of work Nat while <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>6-16</u> , 19 <u>61</u> , to <u>7-26</u> , 19 <u>61</u> , that I last saw the deceased alive on <u>7-26</u> , 19 <u>61</u> , and that death occurred at <u>1 P</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>William R. Ellis</u> M.D.				ADDRESS (Street, city or town, state) <u>Salisbury, Md.</u> DATE SIGNED <u>7-26-61</u>			
PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>7-28-61</u>		22c. NAME OF CEMETERY OR CREMATORY <u>M. P.</u>		22d. LOCATION (City, town, or county) (State) <u>Delmar</u> <u>Del</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>W-S. Marnel Co</u>				ADDRESS <u>Delmar</u>		24a. REC'D BY REGISTRAR DATE <u>JUL 28 '61</u>	
						24b. REGISTRAR'S SIGNATURE <u>Arthur E. Kneal</u>	

(M)

(1)

MEMORANDUM FOR THE DIRECTOR
SUBJECT: [Illegible]
DATE: [Illegible]
TO: [Illegible]
FROM: [Illegible]
[The following text is extremely faint and largely illegible due to the quality of the scan. It appears to be a memorandum detailing an investigation or report.]

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Items 2,8 & 9 Film G292 8/2/61 iwk

CERTIFICATE OF DEATH

Reg. Dist. No. 08603

8614

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Virginia</u> b. COUNTY <u>Acc.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Exmore</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Peninsula General Hospital</u>				d. STREET ADDRESS <u>83X-3</u>			
3. NAME OF DECEASED (Type or print) First <u>Dennis</u> Middle <u>Master</u> Last <u>Tillman</u>				4. DATE OF DEATH Month <u>July</u> Day <u>13</u> Year <u>1961</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct. 15, 1903</u>		9. AGE (In years last birthday) <u>57</u> yrs.	10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>unknown</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>unknown</u>		11. BIRTHPLACE (State or foreign country) <u>unknown</u>		12. CITIZEN OF WHAT COUNTRY? <u>unknown</u>	
13. FATHER'S NAME <u>unknown</u>				14. MOTHER'S MAIDEN NAME <u>unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		INFORMANT		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>ADENOCARCINOMA METASTATIC TO LIVER</u> <u>156.2</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause last. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>HEPATIC CIRRHOSIS</u>							INTERVAL BETWEEN ONSET AND DEATH <u>UNKNOWN</u>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at _____ M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>M. T. Rugg</u>		M.D.		ADDRESS (Street, city or town, state) <u>Salisbury, Md</u>		DATE SIGNED <u>7/13/61</u>	
PHYSICIAN'S NAME (Type) _____							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>REMOVAL</u>		22b. DATE THEREOF <u>7-18-61</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Anatomy Board of Md.</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore 1, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Booker T. West - Salisbury, Maryland</u>				24a. REC'D BY REGISTRAR DATE <u>JUL 20 '61</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Frank</u>	

MEDICAL CERTIFICATION

[illegible]

Item 7 Film G290 7/12/61 lwa
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8615

CERTIFICATE OF DEATH

Reg. Dist. No.

08609

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Virginia</u> b. COUNTY <u>Accomack</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>201 N. Main Chincoteague</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Peninsula General Hospital</u>				d. STREET ADDRESS <u>201 N MAIN ST.</u> 83X-3			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Mary Kathryn Watson</u>				4. DATE OF DEATH Month Day Year <u>July 3 1961</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>May 29, 1901</u>	
9. AGE (In years last birthday) <u>60</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Ireland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>				13. FATHER'S NAME			
14. MOTHER'S MAIDEN NAME <u>Nora Klating</u>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)			
16. SOCIAL SECURITY NO. <u>224-28-2396</u>				INFORMANT Address <u>Clifton Watson - Chincoteague, Virginia</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Subarachnoid Hemorrhage</u> 330X DUE TO <u>Arteriosclerotic Cerebro-Vascular Disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u></u> DUE TO <u></u> (c) <u></u>				INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>June 29, 1961</u> , to <u>July 3, 1961</u> , that I last saw the deceased alive on <u>July 3, 1961</u> , and that death occurred at <u>12:35 P.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Thomas C. Hellyer, M.D.</u>				ADDRESS (Street, city or town, state) <u>Pine Bluff Road</u> DATE SIGNED <u>7/3/61</u>			
PHYSICIAN'S NAME (Type) <u>Salisbury, Maryland</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>July 6, 1961</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Greenwood Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Chincoteague, Virginia</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>William B. Lalyer</u> ADDRESS <u>Chincoteague, Va.</u>				24a. REC'D BY REGISTRAR <u>JUL 10 '61</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Hines</u>	

8616

CERTIFICATE OF DEATH

Reg. Dist. No. 08610

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Somerset</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>				c. LENGTH OF STAY IN 1b <u>Life Time</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>19 X-2</u> <u>LEININGA GENERAL HOSPITAL</u>				d. STREET ADDRESS <u>19 X-2</u>			
3. NAME OF DECEASED (Type or print) First <u>James</u> Middle <u>L.</u> Last <u>Waters</u>				4. DATE OF DEATH Month <u>July</u> Day <u>8</u> Year <u>1961</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>Colored</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>3/25/1901</u>	
9. AGE (In years last birthday) <u>60</u> yrs.		IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min.		IF UNDER 24 HRS. Hours <u>0</u> Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Oyster Shucker</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Shucker Oyster</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U S A.</u>							
13. FATHER'S NAME <u>James E. Waters</u>				14. MOTHER'S MAIDEN NAME <u>Lena Maddox</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u>INFORMANT</u> <u>Lottie Waters, Manokin, Maryland</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumococcal Meningitis</u> DUE TO <u>340-1</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Anemia</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) _____ INTERVAL BETWEEN ONSET AND DEATH _____							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____				20d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) _____ (County) _____ (State) _____							
21. I certify that I attended the deceased from <u>1955</u> , 19 _____, to <u>7/8/61</u> , 19 _____, that I last saw the deceased alive on <u>7/8/61</u> , 19 _____, and that death occurred at <u>3:45 P.M.</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED _____ ACTUAL SIGNATURE <u>W. E. Mitchell</u> M.D. _____ PHYSICIAN'S NAME (Type) _____							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				22b. DATE THEREOF <u>7/12/61</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Samuel Wesley</u>	
22d. LOCATION (City, town, or county) <u>Manokin, Maryland</u>				(State) _____			
23. FUNERAL DIRECTOR'S SIGNATURE <u>William H. James Jr. Princess Anne, Md</u>				ADDRESS _____		24a. REC'D BY REGISTRAR <u>Julius S. Hanna</u>	
DATE <u>Jul 12 '61</u>				24b. REGISTRAR'S SIGNATURE			

MEDICAL CERTIFICATION

02610

RETURN OF DEBT

3618

M

STATE OF MASSACHUSETTS
DEPARTMENT OF REVENUE
RETURN OF DEBT
No. 3618
RETURNED TO THE
DEPARTMENT OF REVENUE
FOR THE YEAR 1911
BY THE
COMMISSIONER OF REVENUE
JANUARY 1, 1912

1

STATE OF MASSACHUSETTS
DEPARTMENT OF REVENUE
RETURN OF DEBT
No. 3618
RETURNED TO THE
DEPARTMENT OF REVENUE
FOR THE YEAR 1911
BY THE
COMMISSIONER OF REVENUE
JANUARY 1, 1912

8617

CERTIFICATE OF DEATH

Reg. Dist. No. 08611

(M)

1. PLACE OF DEATH a. COUNTY <i>Wicomico</i> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Wicomico</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Salisbury</i>				c. LENGTH OF STAY IN 1b 12 hrs.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Peninsula General Hospital</i>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <i>BESSIE</i> First Middle Last <i>WIGHTMAN</i>				4. DATE OF DEATH Month <i>7</i> Day <i>21</i> Year <i>1961</i>			
5. SEX <i>F</i>		6. COLOR OR RACE <i>W</i>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>6/15/1883</i>	
9. AGE (In years last birthday) <i>78</i> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.		11. IF UNDER 24 HRS. Months Days Hours Min.		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>bookkeeper</i>				10b. KIND OF BUSINESS OR INDUSTRY <i>accounts</i>		11. BIRTHPLACE (State or foreign country) <i>Maryland</i>	
13. FATHER'S NAME <i>George W. Wightman</i>				14. MOTHER'S MAIDEN NAME <i>Alice Bond</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>no</i> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <i>215-07-1887</i>		INFORMANT Address <i>Mrs. Alice Perdue Stephens, same</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebral Hemorrhage</i> 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause last. (b) <i>Hypertension</i> DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH <i>6 hrs</i>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>				20d. INJURY OCCURRED While <input type="checkbox"/> at work <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <i>1950</i> , to <i>7/21</i> , 19 <i>61</i> , that I last saw the deceased alive on <i>7/21</i> , 19 <i>61</i> , and that death occurred at <i>8:40 PM</i> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE <i>Fred R. Gramse</i> M.D.				PHYSICIAN'S NAME (Type) <i>Fred R. GRAMSE, MD</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>				22b. DATE THEREOF <i>7/23/61</i>		22c. NAME OF CEMETERY OR CREMATORY <i>Parsonsbury Cemetery</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Hill & Johnson Co.</i>				ADDRESS <i>Salisbury</i>		24a. REC'D BY REGISTRAR DATE <i>JUL 25 '61</i>	
				24b. REGISTRAR'S SIGNATURE <i>Arthur S. Harris</i>		24c. LOCATION (City, town, or county) (State) <i>Parsonsbury Maryland</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

14

14

CERTIFICATE OF DEATH

STATE OF NEW YORK

County of ...
City of ...
I, the undersigned, a duly qualified and licensed physician, do hereby certify that on the ... day of ... 19... at ... o'clock ...
of the age of ... years ...
and that the cause of death was ...

Witness my hand and seal this ... day of ... 19...
at ...
Signature of Physician

Witness my hand and seal this ... day of ... 19...
at ...
Signature of Registrar

Witness my hand and seal this ... day of ... 19...
at ...
Signature of ...

Witness my hand and seal this ... day of ... 19...
at ...
Signature of ...

Witness my hand and seal this ... day of ... 19...
at ...
Signature of ...

Witness my hand and seal this ... day of ... 19...
at ...
Signature of ...

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

1

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
8618
CERTIFICATE OF DEATH
08612

1. PLACE OF DEATH o. COUNTY Wicomico MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Wicomico	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 711 Vermont Ave		d. STREET ADDRESS 711 Vermont Ave	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First MARY Middle ELIZABETH (MAMIE) Last WILLIAMS		4. DATE OF DEATH Month JULY Day 30th Year 1961	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 11, 1870
9. AGE (In years last birthday) 91 yrs.	IF UNDER 1 YEAR Months 5 Days 19	IF UNDER 24 HRS. Hours Min. 	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Work-Retired		10b. KIND OF BUSINESS OR INDUSTRY None	11. BIRTHPLACE (State or foreign country) Shad Point, Maryland
12. CITIZEN OF WHAT COUNTRY? U S A			
13. FATHER'S NAME Samuel Williams		14. MOTHER'S MAIDEN NAME Charlotte Smith	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 	
17. INFORMANT Mr. Linwood Williams (Son)		Address 409 Winder St Salisbury, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 434.1 DUE TO Congenital heart failure Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Tumor in abdomen		INTERVAL BETWEEN ONSET AND DEATH 	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) N/A		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) N/A	
20c. TIME OF INJURY Manth. Day 19 Year 19 Hour o. m. N/A p. m. 		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) N/A		20f. (City or town) N/A (County) (State) 	
21. I certify that (I) (this hospital) attended the deceased from 9-28, 1952 to 6-9, 1961 , that (I) (we) last saw the deceased alive on 19 , and that death occurred at M , from the causes and on the date stated above.			
22a. SIGNATURE Dr. Andrew C. Mitchell		22b. DATE July 31, 1961	
22c. PHYSICIAN'S NAME (Type) Dr. Andrew C. Mitchell		22d. ADDRESS Maryland Ave. Salisbury, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Aug. 1, 1961	
23c. NAME OF CEMETERY OR CREMATORY Shad Point Cemetery-R.D.#		23d. LOCATION (City, town, or county) (State) Salisbury, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE HOLLOWAY & COMPANY		ADDRESS SALISBURY MARYLAND	
25a. RECEIVED BY REGISTRAR Aug 2 '61		25b. REGISTRAR'S SIGNATURE William S. Evans	

013

CENTRE OF DEATH

013

M

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[Faint, illegible text, possibly bleed-through from the reverse side of the page]

1 FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH									
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
8619 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 08613									
Item 2 Film 0293 8/22/61									
1. PLACE OF DEATH a. COUNTY		Wicomico		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)		b. COUNTY	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)		Salisbury		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)		d. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)		Peninsula General Hospital		d. STREET ADDRESS		762 Milestone Drive			
3. NAME OF DECEASED (Type or print)		First Nick		Middle Williams		Last		4. DATE OF DEATH	
5. SEX		M		6. COLOR OR RACE		C		7. MARIED <input checked="" type="checkbox"/> NEVER MARIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH		1899		9. AGE (In years last birthday)		62 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		Labor		10b. KIND OF BUSINESS OR INDUSTRY		Unknown		11. BIRTHPLACE (State or foreign country)	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME				12. CITIZEN OF WHAT COUNTRY?	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		?		16. SOCIAL SECURITY NO.		?		17. INFORMANT	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		Uremia		DUE TO		600.0		INTERVAL BETWEEN ONSET AND DEATH	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		(b) Chronic pyelonephritis		DUE TO				Days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		Cerebral atrophy due to old brain injury: Grand mal epilepsy						Months	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		(County)		(State)		20g. (City or town)		(County)	
20h. (State)		20i. (City or town)		(County)		(State)		20j. (City or town)	
20k. (County)		20l. (State)		20m. (City or town)		(County)		(State)	
20n. (City or town)		(County)		(State)		20o. (City or town)		(County)	
20p. (State)		20q. (City or town)		(County)		(State)		20r. (City or town)	
20s. (County)		20t. (State)		20u. (City or town)		(County)		(State)	
20v. (City or town)		(County)		(State)		20w. (City or town)		(County)	
20x. (State)		20y. (City or town)		(County)		(State)		20z. (City or town)	
20aa. (County)		20ab. (State)		20ac. (City or town)		(County)		(State)	
20ad. (City or town)		(County)		(State)		20ae. (City or town)		(County)	
20af. (State)		20ag. (City or town)		(County)		(State)		20ah. (City or town)	
20ai. (County)		20aj. (State)		20ak. (City or town)		(County)		(State)	
20al. (City or town)		(County)		(State)		20am. (City or town)		(County)	
20an. (State)		20ao. (City or town)		(County)		(State)		20ap. (City or town)	
20aq. (County)		20ar. (State)		20as. (City or town)		(County)		(State)	
20at. (City or town)		(County)		(State)		20au. (City or town)		(County)	
20av. (State)		20aw. (City or town)		(County)		(State)		20ax. (City or town)	
20ay. (County)		20az. (State)		20ba. (City or town)		(County)		(State)	
20bb. (City or town)		(County)		(State)		20bc. (City or town)		(County)	
20bd. (State)		20be. (City or town)		(County)		(State)		20bf. (City or town)	
20bg. (County)		20bh. (State)		20bi. (City or town)		(County)		(State)	
20bj. (City or town)		(County)		(State)		20bk. (City or town)		(County)	
20bl. (State)		20bm. (City or town)		(County)		(State)		20bn. (City or town)	
20bo. (County)		20bp. (State)		20bq. (City or town)		(County)		(State)	
20br. (City or town)		(County)		(State)		20bs. (City or town)		(County)	
20bt. (State)		20bu. (City or town)		(County)		(State)		20bv. (City or town)	
20bv. (County)		20bw. (State)		20bx. (City or town)		(County)		(State)	
20bw. (City or town)		(County)		(State)		20bx. (City or town)		(County)	
20bx. (State)		20by. (City or town)		(County)		(State)		20bz. (City or town)	
20bz. (County)		20ca. (State)		20cb. (City or town)		(County)		(State)	
20cc. (City or town)		(County)		(State)		20cd. (City or town)		(County)	
20cd. (State)		20ce. (City or town)		(County)		(State)		20cf. (City or town)	
20cf. (County)		20cg. (State)		20ch. (City or town)		(County)		(State)	
20ch. (City or town)		(County)		(State)		20ci. (City or town)		(County)	
20ci. (State)		20cj. (City or town)		(County)		(State)		20ck. (City or town)	
20ck. (County)		20cl. (State)		20cm. (City or town)		(County)		(State)	
20cn. (City or town)		(County)		(State)		20co. (City or town)		(County)	
20co. (State)		20cp. (City or town)		(County)		(State)		20cq. (City or town)	
20cq. (County)		20cr. (State)		20cs. (City or town)		(County)		(State)	
20cr. (City or town)		(County)		(State)		20ct. (City or town)		(County)	
20ct. (State)		20cu. (City or town)		(County)		(State)		20cv. (City or town)	
20cv. (County)		20cw. (State)		20cx. (City or town)		(County)		(State)	
20cw. (City or town)		(County)		(State)		20cy. (City or town)		(County)	
20cy. (State)		20cz. (City or town)		(County)		(State)		20da. (City or town)	
20da. (County)		20db. (State)		20dc. (City or town)		(County)		(State)	
20db. (City or town)		(County)		(State)		20dd. (City or town)		(County)	
20dd. (State)		20de. (City or town)		(County)		(State)		20df. (City or town)	
20df. (County)		20dg. (State)		20dh. (City or town)		(County)		(State)	
20dh. (City or town)		(County)		(State)		20di. (City or town)		(County)	
20di. (State)		20dj. (City or town)		(County)		(State)		20dk. (City or town)	
20dk. (County)		20dl. (State)		20dm. (City or town)		(County)		(State)	
20dm. (City or town)		(County)		(State)		20dn. (City or town)		(County)	
20dn. (State)		20do. (City or town)		(County)		(State)		20dp. (City or town)	
20dp. (County)		20dq. (State)		20dr. (City or town)		(County)		(State)	
20dr. (City or town)		(County)		(State)		20ds. (City or town)		(County)	
20ds. (State)		20dt. (City or town)		(County)		(State)		20du. (City or town)	
20du. (County)		20dv. (State)		20dw. (City or town)		(County)		(State)	
20dw. (City or town)		(County)		(State)		20dx. (City or town)		(County)	
20dx. (State)		20dy. (City or town)		(County)		(State)		20dz. (City or town)	
20dz. (County)		20ea. (State)		20eb. (City or town)		(County)		(State)	
20eb. (City or town)		(County)		(State)		20ec. (City or town)		(County)	
20ec. (State)		20ed. (City or town)		(County)		(State)		20ee. (City or town)	
20ee. (County)		20ef. (State)		20eg. (City or town)		(County)		(State)	
20ef. (City or town)		(County)		(State)		20eh. (City or town)		(County)	
20eh. (State)		20ei. (City or town)		(County)		(State)		20ej. (City or town)	
20ej. (County)		20ek. (State)		20el. (City or town)		(County)		(State)	
20ek. (City or town)		(County)		(State)		20em. (City or town)		(County)	
20em. (State)		20en. (City or town)		(County)		(State)		20eo. (City or town)	
20eo. (County)		20ep. (State)		20eq. (City or town)		(County)		(State)	
20eq. (City or town)		(County)		(State)		20er. (City or town)		(County)	
20er. (State)		20es. (City or town)		(County)		(State)		20et. (City or town)	
20et. (County)		20eu. (State)		20ev. (City or town)		(County)		(State)	
20ev. (City or town)		(County)		(State)		20ew. (City or town)		(County)	
20ew. (State)		20ex. (City or town)		(County)		(State)		20ey. (City or town)	
20ey. (County)		20ez. (State)		20fa. (City or town)		(County)		(State)	
20fa. (City or town)		(County)		(State)		20fb. (City or town)		(County)	
20fb. (State)		20fc. (City or town)		(County)		(State)		20fd. (City or town)	
20fd. (County)		20fe. (State)		20ff. (City or town)		(County)		(State)	
20ff. (City or town)		(County)		(State)		20fg. (City or town)		(County)	
20fg. (State)		20fh. (City or town)		(County)		(State)		20fi. (City or town)	
20fi. (County)		20fj. (State)		20fk. (City or town)		(County)		(State)	
20fj. (City or town)		(County)		(State)		20fl. (City or town)		(County)	
20fl. (State)		20fm. (City or town)		(County)		(State)		20fn. (City or town)	
20fn. (County)		20fo. (State)		20fp. (City or town)		(County)		(State)	
20fp. (City or town)		(County)		(State)		20fq. (City or town)		(County)	
20fq. (State)		20fr. (City or town)		(County)		(State)		20fs. (City or town)	
20fs. (County)		20ft. (State)		20fu. (City or town)		(County)		(State)	
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1 FOR STATE HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

8620 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08614

Item 9 File 6292 8/2/61

1. PLACE OF DEATH a. COUNTY Wicomico		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. LENGTH OF STAY IN 1b MARYLAND		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		d. STREET ADDRESS Bailey Lane		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) John Francis Wilson		4. DATE OF DEATH Month 7 Day 26 Year 1961		5. SEX M		6. COLOR OR RACE C		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH 1-16-06-55		9. AGE (In years last birthday) 54 Yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Labor		10b. KIND OF BUSINESS OR INDUSTRY none		11. BIRTHPLACE (State or foreign country) Dames Quarter		12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME John Wilson		14. MOTHER'S MAIDEN NAME Leah Dugg		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no	
16. SOCIAL SECURITY NO. 3		17. INFORMANT Lucille Brown		18. ADDRESS Lucille Brown		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Lobar pneumonia 490X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c) DUE TO		INTERVAL BETWEEN ONSET AND DEATH Days			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)												19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)											
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)		(State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>													
ACTUAL SIGNATURE Earl L. Royer, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED 7-28-61		22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Aug 1-61	
EXAMINER'S NAME (Type)		22c. NAME OF CEMETERY OR CREMATORY Dames Quarter		22d. LOCATION (City, town, or country) Salisbury Md		22e. ADDRESS (Street, city, town, or county) Salisbury Md		24a. REC'D BY REGISTRAR AUG 2 '61		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus			
23. FUNERAL DIRECTOR Booker McWest		ADDRESS		24a. REC'D BY REGISTRAR AUG 2 '61		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus		24c. ADDRESS (Street, city, town, or county)		24d. DATE			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MEDICAL CERTIFICATION



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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8621

CERTIFICATE OF DEATH

Reg. Dist. No. 08615

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Quantico				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Quantico			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION R.F.D. # 2 Quantico Md.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Annie		First Annie Middle Winder Last Winder		4. DATE OF DEATH July 4 1961		Month July Day 4 Year 1961	
5. SEX F.	6. COLOR OR RACE C.	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH December 3, 1870		9. AGE (In years last birthday) 90 yrs.	IF UNDER 1 YEAR <input type="checkbox"/> IF UNDER 24 HRS. <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland	
13. FATHER'S NAME Warren Wright				14. MOTHER'S MAIDEN NAME Carolyn Wright			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)				16. SOCIAL SECURITY NO. Ruth Jones Quantico Md. R.F.D. 2			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 422.1 DUE TO Degenerative Heart Disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Atherosclerosis (c) Indefinite				INTERVAL BETWEEN ONSET AND DEATH 6 mo			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year 19 Hour a. m. 1 p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) Quantico (County) Wicomico (State) Md.				20g. (City or town) Quantico (County) Wicomico (State) Md.			
21. I certify that I attended the deceased from 2 Oct. 1960 to 4 July 1961 that I last saw the deceased alive on 4 July 1961 and that death occurred at M from the causes and on the date stated above.							
ACTUAL SIGNATURE E. A. Hurnell M.D. 6520 Main				DATE SIGNED 14 July 61			
PHYSICIAN'S NAME (Type) E. A. Hurnell				ADDRESS (Street, city or town, state) Salisbury, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF July 9 1961		22c. NAME OF CEMETERY OR CREMATORY Quantico		22d. LOCATION (City, town, or county) Quantico Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Clinton F. Stewart ADDRESS Salisbury Md.				24a. REC'D BY REGISTRAR JUL 17 '61 DATE JUL 17 '61		24b. REGISTRAR'S SIGNATURE Arthur S. Thomas	

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CERTIFICATE OF DEATH

NAME

LAST NAME

DATE OF BIRTH

DATE OF DEATH

PLACE OF BIRTH

DATE OF DEATH

PLACE OF DEATH

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PLACE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 9 Film 6292 8/7/61 iwk

8622

CERTIFICATE OF DEATH

Reg. Dist. No. 08616

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>WORCHESTER</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SALISBURY</u>		c. LENGTH OF STAY IN 1b <u>5 Days</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>PENINSULA GENERAL HOSP.</u>		d. STREET ADDRESS <u>23X-2</u>	
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>RICHARD</u> Middle <u>WOODEN</u> Last <u>WOODEN</u>		4. DATE OF DEATH Month <u>July</u> Day <u>22</u> Year <u>1961</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept 16 - 1914</u>
9. AGE (In years last birthday) <u>46 1/4</u> yrs.		10. UNDER 1 YEAR <input type="checkbox"/> IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>LABORER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>none</u>	
11. BIRTHPLACE (State or foreign country) <u>Wilson N.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Charles Weaver</u>		14. MOTHER'S MAIDEN NAME <u>Josephine Jones</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>229-07-2365</u>	
17. INFORMANT <u>Emma Roanice Wilson N.C.</u>		Address <u>Wilson N.C.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>INTRACEREBRAL Hemorrhage</u> DUE TO <u>Neurovascular syphilis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>10-12 yrs.?</u> (c) <u></u>		INTERVAL BETWEEN ONSET AND DEATH <u>5 Days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> at work Nat white <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>July 17, 1961</u> , to <u>July 22, 1961</u> , that I last saw the deceased alive on <u>July 22, 1961</u> , and that death occurred at <u>7:27 P.M.</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>George A. Henning</u> M.D.		ADDRESS (Street, city or town, state) <u>Frederick, Md.</u> DATE SIGNED <u>7/22/61</u>	
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>July 29, 61</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Sunderland Cem</u>		22d. LOCATION (City, town, or county) (State) <u>Kingston N.C.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Booker M. West</u>		ADDRESS <u>139 Second St Salisbury, Md.</u>	
24a. REC'D BY REGISTRAR <u>JUL 27 '61</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Thomas</u>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
8623											
CERTIFICATE OF DEATH											
08617											
1. PLACE OF DEATH e. COUNTY Wicomico MARYLAND						2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fruitland				c. LENGTH OF STAY IN 1b all her life				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fruitland			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Washington Street						d. STREET ADDRESS Washington Street				a. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Helen Middle Victoria Last Wright						4. DATE OF DEATH Month 7 Day 3 Year 19 61					
5. SEX FM		6. COLOR OR RACE AA		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH March 14, 1928		9. AGE (In years last birthday) 33 yrs.		IF UNDER 1 YEAR Months 7 Days 3	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Invalid				10b. KIND OF BUSINESS OR INDUSTRY XXXXXX		11. BIRTHPLACE (County & State, or foreign country) Maryland				12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME St Clair Wright						14. MOTHER'S MAIDEN NAME Durcilla Dashiell					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO				16. SOCIAL SECURITY NO. NONE		17. INFORMANT Miss Drucilla Wright, Fruitland, Md				Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis 4-20-61 DUE TO Conditions, if any, which gave rise to immediate cause (b) Arteriosclerosis (c) DUE TO (e), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m. 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) 21. I certify that (I) (this hospital) attended the deceased from 19 Jan 1961 to 3 July 1961 , that (I) (we) last saw the deceased alive on 3 July 1961 , and that death occurred 30 M, from the causes and on the date stated above. 22a. SIGNATURE E. A. Purnell M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22c. PHYSICIAN'S NAME (Type) E. A. Purnell, M. D. 22d. ADDRESS 657 West Main St., Salisbury, Md 22b. DATE SIGNED 11 July 61 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial 23b. DATE THEREOF 7/7/ 1961 23c. NAME OF CEMETERY OR CREMATORY Mt. Calvary Com. 23d. LOCATION (City, town or county) (State) Fruitland, Md 24. FUNERAL DIRECTOR'S SIGNATURE Thernton B. Jelley, Salisbury, Md ADDRESS 657 West Main St., Salisbury, Md 25a. REC'D BY REGISTRAR JUL 13 '61 25b. REGISTRAR'S SIGNATURE Arthur S. Kraus											

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

8624

Item 225, Film G291 7/25/61 jwk

Reg. Dist. No. 08613

1. PLACE OF DEATH a. COUNTY <u>Worcester</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, If Institution: Residence before admission) o. STATE <u>CONNECTICUT</u> COUNTY <u>NEW HAVEN</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Ocean City</u>		c. LENGTH OF STAY IN 1b <u>3 days</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>55th St & Beach Highway</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>MRS. Julia Agnes COOK</u>		4. DATE OF DEATH Month Day Year <u>July 11 1961</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>MAR 3 1891</u>
9. AGE (In years last birthday) <u>70</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>	
11. BIRTHPLACE (State or foreign country) <u>New Britain Conn</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>COOKE</u>		14. MOTHER'S MAIDEN NAME <u>UNKNOWN</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>046-26-8397</u>	
17. INFORMANT <u>Mrs. Walter J. Turek (Daughter)</u>		Address <u>49 Prescott St Meriden Conn</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion aorta</u> 420.6 DUE TO <u>Hypertensive CVD</u> Conditions, if any, which gave rise to immediate cause (b) <u>44-ars</u> (c) <u>44-ars</u> DUE TO <u>44-ars</u> (d) <u>44-ars</u> stating the underlying cause lost.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Obesity</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH <u>INSTANT</u>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>Francis J. Townsend Jr.</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>FRANCIS J. TOWNSEND JR ASST</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <u>July 11, 61</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>July 14, 1961</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Berlin Ind</u>		22d. LOCATION (City, town, or county) (State) <u>Meriden Conn.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Anna A. Burkay</u>		24a. REC'D BY REGISTRAR <u>Arthur S. Frank</u>	
ADDRESS <u>Berlin Ind</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Frank</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any entry is necessary, please enclose certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

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